

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

JAMES KELLY MONROE (AIS# 167435),

Plaintiff,

v.

OFFICER L. THOMAS, et al.

Defendants.

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CIVIL ACTION: 2:06CV-928-MEF

SPECIAL REPORT OF DEFENDANTS
PRISON HEALTH SERVICES, INC., CHERYL WEBB,
GENE LYSYKANYCZ, L.P.N., AND PAUL CORBIER, M.D.

COME NOW Defendants, Nurse Cheryl Webb, Gene Lysykanycz, L.P.N., Paul Corbier, M.D., along with Prison Health Services, Inc. (hereinafter "PHS"), by and through counsel, and in response to this Honorable Court's order requesting a Special Report, submits the following Special Report with regards to this case:

I. INTRODUCTION

The plaintiff, James Kelly Monroe (AIS# 167435), asserts separate claims against PHS and its physicians and nurses and the Alabama Department of Corrections and certain correctional officers. Both claims arise out of a stabbing which occurred on or about September 4, 2006. On October 13, 2006, Monroe filed his complaint against the Alabama Department of Corrections, multiple correctional officers, and PHS, specifically, Nurse Cheryl Webb, Gene Lysykanycz, L.P.N., and Paul Corbier, M.D. In these allegations against PHS, Cheryl Webb, Gene Lysykanycz, L.P.N., Paul Corbier, M.D., Monroe claims that his

constitutional rights were violated by providing him with inadequate medical care associated with the stabbing incident on September 4th. [See Complaint].

As ordered by this Court, the Defendant PHS, et al. have undertaken a review of Monroe's claims to determine the facts and circumstances arising out of the stabbing incident and its subsequent medical care. As a result of this investigation, these Defendants are submitting this Special Report supported by a certified copy of Monroe's medical records [Exhibit "A"], an affidavit of Dr. Paul Corbier [Exhibit "B"], and an affidavit of Darryl King [Exhibit "C"]. These evidentiary materials demonstrate that Monroe failed to follow mandatory internal procedures for review of medical claims, and that Monroe's medical treatment has been proper at all times. Thus, his treatment does not, under any circumstances, rise to the level of a deliberate indifference to a serious medical condition.

II. NARRATIVE SUMMARY OF FACTS

At all times pertaining to this claim, Monroe was incarcerated at Staton Correctional Facility in Elmore, Alabama. [See Exhibits "A" and "B"]. Monroe has been seen and evaluated by Staton's medical or nursing staff and has received appropriate care from the applicable provider each time he has registered health complaints at Staton. [Exhibit "A"]. In this particular case, Monroe claims deliberate indifference to a serious medical need arising out of treatment received by him for a stabbing that occurred on September 4, 2006.

Staton medical records note that Monroe presented to the emergency facility at 7:40 p.m. on September 4th complaining of a stab wound in his mid-back. [Exhibit "E"]. Nursing notes indicate a 2.5 cm stab wound on the right side of the spine below the shoulder blades. [Id.]. Monroe complained of pain when asked to take a deep breath to check lung sounds and

eventually made continuous complaints of pain. [Id.]. The nursing staff reported the condition to Dr. Corbier, who immediately ordered Monroe's transfer to Baptist South Emergency Room via Department of Correction vans. [Id.].

Upon arrival at Baptist Health Center, the nursing staff confirmed the stab wound to the back and immediately prescribed morphine as a pain medication. [Id.]. X-rays were taken to determine whether additional internal injuries had occurred, the results of which were negative. [Id.]. On discharge, the Baptist medical staff prescribed Keflex and Lorcet to deal with pain associated with the injury and ordered Monroe to follow-up with Prison healthcare officials to have staples removed within 7-10 days.

On September 11, 2006, Monroe returned to Dr. Corbier's office for the removal of his staples. Staples were removed from the upper back and elbow, but Monroe continued to complain about acute right ribcage pain. Corbier prescribed Motrin for a few additional days and advised Monroe to return to the clinic if the pain did not subside. [Id.].

On September 21, 2006, Monroe reported feelings of paranoia since his stabbing. He also threatened litigation arising out of the incident. Notes indicated strong feelings of paranoia. PHS agreed to continue to follow-up with Monroe on an "as needed" basis. [Id.].

On October 23, 2006 (10 days after filing of his Complaint), Monroe complained that although paranoid, he did not want any medication and had begun to deal with his issues. [Id.]. Furthermore, Monroe had no other complaints at that time. [Id.].

Prior to filing his lawsuit in federal court, Monroe did not utilize the grievance procedures in place to address his medical treatment. The Staton Correctional Facility has a set of grievance procedures specifically related to health complaints, which are required to be followed by prisoners. [Exhibit "D"]. These grievance procedures require that inmates

notify the medical staff of a concern regarding their medical treatment. [Id.]. If necessary, an inmate like Monroe will be interviewed and his grievance reviewed within a three (3) day period. [Id.]. If, after meeting with an inmate, the grievance cannot be resolved to the inmate's satisfaction, an appeal may be filed by the prisoner which will allow his initial written grievance to be re-reviewed in its entirety. In this case, Monroe did not follow any of these procedures in either a proper or timely manner. [Exhibit "C" – Affidavit Darryl King].

III. DEFENSES

The Defendants assert the following defenses to the Plaintiff's claims:

1. The Plaintiff/prisoner failed to comply with the mandatory requirements of the Prison Litigation Reform Act of 1995, 42 U.S.C. §1997(e), et seq. ("PLRA") and the PLRA directly applies to require that this matter be dismissed with prejudice for failing to comply with the terms and conditions of grievance procedures concerning medical issues.
2. The Defendants deny each and every material allegation contained in the Plaintiff's Complaint and demand strict proof thereof.
3. The Defendants plead not guilty to the charges in the Plaintiff's Complaint.
4. The Plaintiff's Complaint, as amended, fails to state a claim against the Defendants for which relief can be granted.
5. The Defendants affirmatively deny any and all alleged claims by the Plaintiff.
6. The Plaintiff is not entitled to any relief requested in the Complaint, as amended.
7. The Defendants plead the defense of qualified immunity and avers that the actions taken by the Defendants were reasonable and in good faith with reference to clearly established law at the time of the incidents complained of by the Plaintiff.

8. The Defendants are entitled to qualified immunity and it is clear from the face of the Complaint, as amended, that the Plaintiff has not alleged specific facts indicating that the Defendants have violated any clearly established constitutional right.

9. The Defendants cannot be held liable on the basis of respondeat superior, agency, or vicarious liability theories.

10. The Plaintiff is not entitled to any relief under 42 U.S.C. § 1983.

11. The allegations contained in the Plaintiff's Complaint, as amended, against the Defendants sued in their individual capacities, fails to comply with the heightened specificity requirement of Rule 8 in § 1983 cases against persons sued in their individual capacities. See Oladeinde v. City of Birmingham, 963 F.2d 1481, 1485 (11th Cir. 1992); Arnold v. Board of Educ. Of Escambia County, 880 F.2d 305, 309 (11th Cir. 1989).

12. The Defendants plead all applicable immunities, including, but not limited to qualified, absolute, discretionary function immunity, and state agent immunity.

13. The Defendants aver that they were at all times acting under color of state law and, therefore, they are entitled to substantive immunity under the law of the State of Alabama.

14. The Defendants plead the general issue.

15. This Court lacks subject matter jurisdiction due to the fact that even if the Plaintiff's allegations should be proven, the allegations against the Defendants would amount to mere negligence which is not recognized as a deprivation of the Plaintiff's constitutional rights. See Rogers v. Evans, 792 F.2d 1052 (11th Cir. 1986).

16. The Plaintiff's claims against the Defendants in their official capacities are barred by the Eleventh Amendment to the United States Constitution.

17. Alabama law provides tort and other remedies for the allegations made by the Plaintiff herein and such remedies are constitutionally adequate.

18. The Defendants plead the defense that at all times in treating Plaintiff they exercised the same degree of care, skill, and diligence as other physicians and nursing staff would have exercised under similar circumstances and that at no time did they act toward the Plaintiff with deliberate indifference to a serious medical need.

19. The Defendants plead the affirmative defense that the Plaintiff's Complaint, as amended, fails to contain a detailed specification and factual description of the acts and omissions alleged to render them liable to the Plaintiff as required by § 6-5-551 of the Ala. Code (1993).

20. The Defendants plead the affirmative defenses of contributory negligence and assumption of the risk.

21. The Defendants plead the affirmative defense that Plaintiff's damages, if any, were the result of an independent, efficient, and/or intervening cause.

22. The Defendants plead the affirmative defense that they are not responsible for the policies and procedures of the Alabama Department of Corrections.

23. The Defendants plead the affirmative defense that the Plaintiff has failed to mitigate his own damages.

24. The Defendants plead the affirmative defense that they are not guilty of any conduct which would justify the imposition of punitive damages against it and that any such award would violate the United States Constitution.

25. The Defendants adopt and assert all defenses set forth in the Alabama Medical Liability Act § 6-5-481, et seq., and § 6-5-542, et seq.

26. The Plaintiff has failed to comply with 28 U.S.C. § 1915 with respect to the requirements and limitations inmates must follow in filing in forma pauperis actions in federal court.

27. Pursuant to 28 U.S.C. § 1915 A, this Court is requested to screen and dismiss this case, as soon as possible, either before or after docketing, as this case is frivolous or malicious, fails to state a claim upon which relief may be granted, or seeks money damages from the Defendants who are state officers entitled to immunity as provided for in 42 U.S.C. § 1997 (e)(c).

28. The Defendants assert that the Plaintiff's Complaint, as amended, is frivolous and filed in bad faith solely for the purpose of harassment and intimidation and requests this Court pursuant to 42 U.S.C. § 1988 to award Defendants reasonable attorney's fees and costs incurred in the defense of this case.

29. The Plaintiff's claims are moot because the events which underlie the controversy have been resolved. See Marie v. Nickels, 70 F., Supp. 2d 1252 (D. Kan. 1999).

IV. ARGUMENT

A. Because Inmate Monroe Failed to Follow the Required Grievance Procedures for Assessing Medical Complaints Prior to Filing His Lawsuit, the Prison Litigation Reform Act of 1995 Requires the Immediate Dismissal, with Prejudice, of His Complaint.

With the explosion of prisoner cases becoming epidemic, Congress passed the Prison Litigation Reform Act of 1995 in an effort to control frivolous prisoner litigation. The Act is wide ranging and contains multiple, mandatory provisions that require the dismissal of complaints identical to that asserted by Mr. Monroe.

The PLRA defines a prisoner as follows:

As used in this section, the term “prisoner” means any person incarcerated or detained in any facility who is accused of, convicted of, sentenced for, or adjudicated delinquent for, violations of criminal law or the terms and conditions of parole, probation, pretrial release, or diversionary program. 42 U.S.C. §1997e(h).

Because Monroe admits to being incarcerated in his complaint, he meets the definition of “prisoner” as defined by the PLRA. See Boyd v. Corrections Corporation of America, 380 F.3d 989 (6th Cir. 2004).

The crux of the PLRA requires a prisoner to exhaust all internal, administrative remedies prior to filing suit. The PLRA requires that the Court on its motion or the motion of a defendant dismiss any action with respect to prisoner conditions or medical treatment upon failure to exhaust these remedies. 42 U.S.C. §1997e(a). This provision states the following:

(a) Applicability of Administrative Remedies.

No action shall be brought with respect to prison conditions under section 1983 of this title, or any other Federal law, by a prisoner confined in any jail, prison, or other correctional facility until such administrative remedies as are available are exhausted. (emphasis added).

(b) Failure of State to Adopt or Adhere to Administrative Grievance Procedure.

The failure of a State to adopt or adhere to an administrative grievance procedure shall not constitute the basis for an action under 1997a or 1997c of this Title.

(c) Dismissal

The Court shall on its own motion or on the motion of a party dismiss any action brought with respect to prison conditions under section 1983 of this title, or any other Federal law, by a prisoner confined in any jail, prison, or other correctional facility if the court is satisfied that the action is frivolous, malicious, fails to state a claim upon which relief can be granted, or seeks monetary relief from a defendant who is immune from such relief.

42 U.S.C. § 1997e(a)

“Administrative remedies” pursuant to this Act constitute prison or jail grievance procedures such as those identified in this Special Report. Before filing suit, the prison/plaintiff must submit his claim through these procedures and the grievance must address the specific issue upon which the suit is based. Failure to strictly follow these procedures requires dismissal of the action. Even if the prisoner/plaintiff has no knowledge regarding the existence of the procedures, this does not relieve the requirement. See Zolicoffer v. Scott, 55 F. Supp. 2d 1372 (N.D. Ga. 1999), affirmed without opinion (252 F.3d 440 (11th Cir. 2001)).

It is undisputed that Monroe failed to follow the appropriate administrative procedures associated with his claim for inadequate medical care. [Exhibit “C” – Affidavit Darryl King]. Because Monroe failed to follow internal procedures concerning these grievances, his claim must be dismissed with prejudice for failing to comply with these mandatory administrative remedies. Woodford v. NGO, 126 S. Ct. 2378, 165 L.Ed.2d 368 (2006).

The Woodford case is extremely instructive because the United States Supreme Court took the opportunity to clarify issues concerning the Prison Litigation Reform Act. In Woodford, a California state prisoner challenged a disciplinary act but did so in an untimely manner, violating California’s Prison Grievance System. Subsequently, the prisoner sued the system in federal court, but the district court granted the Department’s Motion to Dismiss, stating the prisoner had not fully exhausted his administrative remedies, pursuant to the Prison Litigation Reform Act. On appeal, the Ninth Circuit reversed, claiming that because no administrative remedies remained available to the prisoner, he had “not exhausted them” amongst other reasons.

On appeal, the United States Supreme Court reversed the Ninth Circuit and affirmed the dismissal of the prisoner's complaint. The Court's opinion focused extensively on the "exhaustion" of available remedies and concluded that whether procedural deficiencies existed or whether a prisoner is poorly educated and unfamiliar with such proceedings, it is a requirement that administrative remedies be followed prior to litigation ensuing in federal court. *Id.* At 2387, 2388, 2390, 2392-2393.

B. The Plaintiff has failed to prove that the Defendants acted with deliberative indifference to any serious medical need.

A court may dismiss a complaint for failure to state a claim if it is clear that no relief could be granted under any set of facts that could be proven consistent with the allegations in the complaint. *Romero v. City of Clanton*, 220 F. Supp. 2d 1313, 1315 (M.D. Ala., 2002), (citing, *Hishon v. King & Spalding*, 467 U.S. 69, 73, (1984). "Procedures exist, including Federal Rule of Civil Procedure 7(a), or Rule 12(e), whereby the trial court may "protect the substance of qualified immunity," *Shows v. Morgan*, 40 F. Supp. 2d 1345, 1358 (M.D. Ala., 1999). A careful review of Monroe's medical records reveals that he has been given appropriate medical treatment at all times. (See Exhibits "A" & "B"). All of the allegations contained within Monroe's Complaint, as amended, are either inconsistent with his medical records, or are claims for which no relief may be granted. (*Id.*) Therefore, Monroe's claims against the Defendants are due to be dismissed.

In order to state a cognizable claim under the Eighth Amendment, Monroe must allege acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs. See *Estelle v. Gamble*, 429 U.S. 97, 106 (U.S. 1976); *McElligott v. Foley*, 182 F.3d 1248, 1254 (11th Cir. 1999); *Palermo v. Corr. Med. Servs.*, 148 F. Supp. 2d 1340, 1342 (S.D. Fla. 2001). In order to prevail, Monroe must allege and prove that he suffered from a serious

medical need, that the Defendants were deliberately indifferent to his needs, and that he suffered harm due to deliberate indifference. See Marsh v. Butler County, 268 F.3d 1014, 1058 (11th Cir. 2001) and Palermo, 148 F. Supp. 2d at 1342. “Neither inadvertent failure to provide adequate medical care nor a physician's negligence in diagnosing or treating a medical condition states a valid claim of medical mistreatment under the Eighth Amendment.” Id. (citations omitted).

Not every claim by a prisoner that medical treatment has been inadequate states an Eighth Amendment violation. Alleged negligent conduct with regard to inmates’ serious medical conditions does not rise to the level of a constitutional violation. Alleged medical malpractice does not become a constitutional violation merely because the alleged victim is a prisoner. See Estelle, 429 U.S. at 106, McElligott, 182 F.3d at 1254, Hill, 40 F.3d 1176, 1186 (11th Cir. 1994), Palermo, 148 F. Supp. 2d at 1342. Further, a mere difference of opinion between an inmate and the physician as to treatment and diagnosis cannot give rise to a cause of action under the Eighth Amendment. Estelle, 429 U.S. at 106-108.

The Defendants may only be liable if they had knowledge of Monroe’s medical condition, Hill, 40 F. 3d at 1191, and acted intentionally or recklessly to deny or delay access to his care, or to interfere with treatment once prescribed. Estelle, 429 U.S. at 104-105. Obviously, Monroe cannot carry his burden. The evidence submitted with this Special Report clearly shows that the Defendants did not act intentionally or recklessly to deny or delay medical care, or to interfere with any treatment which was prescribed or directed. The evidence demonstrates, to the contrary, that appropriate standards of care were followed at all times. (Id.) These facts clearly disprove any claim that the Defendants acted intentionally or recklessly to deny treatment or care.

The Defendants are, further, entitled to qualified immunity from all claims asserted by Monroe in this action. There is no argument that the Defendants were not acting within the scope of their discretionary authority. See Eubanks v. Gerwen, 40 F. 3d 1157, 1160 (11th Cir. 1994); see also Jordan v. Doe, 38 F. 3d 1559, 1566 (11th Cir. 1994). Because the Defendants have demonstrated that they were acting within the scope of their discretionary authority, the burden shifts to Monroe to show that the Defendants violated clearly established law based upon objective standards. Eubanks, 40 F. 3d at 1160. The Eleventh Circuit requires that before the Defendants' actions can be said to have violated clearly established constitutional rights, Monroe must show that the right allegedly violated was clearly established in a fact-specific, particularized sense. Edwards v. Gilbert, 867 F.2d 1271, 1273 (11th Cir. 1989), aff'd in pertinent part, rev'd in part on other grounds, sub nom., Edwards v. Okaloosa County, 5 F. 3d 1431 (11th Cir. 1989).

The Eleventh Circuit further requires that the inquiry be fact specific, and that officials will be immune from suit if the law with respect to their actions was unclear at the time the cause of action arose, or if a reasonable person could have believed that their actions were lawful in light of clearly established law and information possessed by the individual. See Brescher v. Von Stein, 904 F.2d 572, 579 (11th Cir. 1990) (quoting, Anderson v. Creighton, 483 U.S. 635, 640, (U. S. 1987)). The question that must be asked is whether the state of the law in 2006 gave the Defendants fair warning that their alleged treatment of Monroe was unconstitutional. Hope v. Pelzer, 536 U.S. 730, 741 (U.S. 2002).

Therefore, to defeat summary judgment, Monroe must be able to point to cases with "materially similar" facts, within the Eleventh Circuit, that would alert the Defendants to the fact that their practice or policy violates his constitutional rights. See Hansen v.

Soldenwagner, 19 F.3d 573, 576 (11th Cir. 1994). In order for qualified immunity to be defeated, preexisting law must “dictate, that is truly compel (not just suggest or allow or raise a question about), the conclusion for every like-situated, reasonable government agent that what the defendant is doing violates federal law in the circumstances.” Lassiter v. Alabama A & M Univ., Bd. of Trustees, 28 F. 3d 1146, 1151 (11th Cir. 1994). The Defendants submit that there is no case law from the United States Supreme Court, the Eleventh Circuit Court of Appeals, or District Courts sitting within the Eleventh Circuit showing that, under the facts of this case, it was clearly established that these alleged actions violated Monroe’s constitutional rights. All of Monroe’s medical needs have been addressed or treated. (See Exhibits “A” & “B”). The Defendants have provided Monroe with appropriate medical care at all times and he has received appropriate nursing care as indicated for treatment of his condition.

V. CONCLUSION

The Plaintiff’s Complaint, as amended is due to be dismissed on its face, and is, further, disproven by the evidence now before the Court. All of the Plaintiff’s requests for relief are without merit. The Defendants have demonstrated both through substantial evidence and appropriate precedent that there is not any genuine issue of material fact relating to a constitutional violation, and that they are, therefore, entitled to a judgment in their favor as a matter of law. The Plaintiff’s submissions clearly fail to meet his required burden.

Accordingly, the Defendants request that this Special Report be treated and denominated as a Motion to Dismiss and/or a Motion for Summary Judgment and that this Honorable

Court either dismiss the Plaintiff's Complaint, as amended, with prejudice, or enter a judgment in their favor.

Respectfully submitted,

/s/ PAUL M. JAMES, JR.
Alabama State Bar Number JAM017
Attorney for Defendants Prison Health
Services, Inc., Paul Corbier, M.D., Eugene
Lysykanycz, L.P.N., and Cheryl Webb

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CERTIFICATE OF SERVICE

I hereby certify that a copy of the above and foregoing has been served by U.S. Mail
this the 16th day of January, 2007, to:

James K. Monroe (AIS# 167435)
Staton Correctional Facility
P. O. Box 56
Elmore, AL 36025

/s/ PAUL M. JAMES, JR. (JAM017)
Attorney for Defendants Prison Health
Services, Inc., Paul Corbier, M.D., Eugene
Lysykanycz, L.P.N., and Cheryl Webb

EXHIBIT A

AFFIDAVIT

STATE OF ALABAMA)

COUNTY)

I, Tommie Ellerbee, hereby certify and affirm that I am a medical clerk, at Staton Healthcare; that I am one of the custodians of medical records at this institution; that the attached documents are true, exact, and correct photocopies of certain medical records maintained here in the institution medical file of one JAMES Monroe, AIS# 164435; and that I am over the age of twenty-one years and am competent to testify to the aforesaid documents and matters stated therein.

I further certify and affirm that said documents are maintained in the usual and ordinary course of business at _____; and that said documents (and the entries therein) were made at, or reasonably near, the time that by, or from information transmitted by, a person with knowledge of such acts, events, and transactions referred to therein are said to have occurred.

This, I do hereby certify and affirm to on this the 30 day of November 2006

SWORN TO AND SUBSCRIBED BEFORE ME THIS THE

30 Day of November, 2006Annie Tate
Notary Public12/06/2008
My Commission Expires

ALABAMA DEPARTMENT OF CORRECTIONS

PROBLEM LIST

INMATE NAME Monroe, James Kelly AIS# 167435Medication Allergies: NKDAMedical: Chronic (Long-Term) Problems
Roman Numerals for Medical/SurgicalMental Health Code SMI HARM HIST NONE
Capital Letter for Psychiatric BehaviorMH-0MH=0
SB, MD.
6/27/08

Date Identified	Chronic Medical Problem	Mental Health Code	Date Resolved	Provider Initials
8-4-04	14mm Tuscaloosa County Jail			
12/20/05	MH code SMI			SB, MD
4/12/06	Δ code + 0 :	<u>MH-0</u>		Dr. Tom
6/27/06	MH code 0			SB, MD
9/26/06	Adjustment D/o e Depressed mood	MH = 1		SB, MD

**If Asthmatic label: Mild – Moderate – or Severe.

STATE OF ALABAMA
DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES

TREATMENT PLAN REVIEW

Application and Review Frequency:

Crisis Cell: M H Observation Suicide Watch (each working day) Outpatient ☒ (6 months)
RTU: (weekly, bimonthly, monthly) SU: (weekly)

Problem # 1 Initiation Date: 9/26/06 Resolution Target Date: 3/26/07 Status: Resolved ☐ No Change ☐ Modified ☒

Outcome/modifications:

Inmate's Sxs of depression have increased due to situational stressors. He was recently stabbed in the back by another inmate. Will continue 1:1 counseling.

Responsible staff: Ph.D Frequency: Monthly

Problem # 2 Initiation Date: 9/26/06 Resolution Target Date: 3/26/07 Status: Resolved ☒ No Change ☐ Modified ☐

Outcome/modifications:

Inmate no longer has a problem w/ energy level. Problem resolved.

Responsible staff: _____ Frequency: _____

Problem # 3 Initiation Date: _____ Resolution Target Date: _____ Status: Resolved ☐ No Change ☐ Modified ☐

Outcome/modifications:

Inmate's difficulty concentrating has improved. Will continue with therapy sessions.

Responsible staff: Ph.D Frequency: Monthly

Problem # 4 Initiation Date: 9/26/06 Resolution Target Date: 3/26/07 Status: Resolved ☐ No Change ☐ Modified ☐

Outcome/modifications:

Inmate feels nervous, jittery and fearful at times due to recent stabbing. Will provide 1:1 sessions to alleviate Sxs.

Responsible staff: Ph.D Frequency: Monthly

Treatment Coordinator: Teresa Torres, Psy.D. Date: 9/26/06

Inmate Name: Monroe, James

RTU Level: _____

AIS #: 167435

Disposition: Inmate Medical Record

Reference: ADCCAR: 622,623,630,632,61,635,638

ADOC Form MH-034 - Novemb 14, 2005

Page: _____ of _____

new
problem

STATE DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES
TREATMENT PLAN: OUTPATIENT CARE

Treatment Plan Initiated on: 03/20/06 Treatment Coordinator: Steve Smith

Inmate's Housing Location: _____ Institution: Cmore

DSM IV Diagnosis: adjustment D/O - depressed mood

Axis I: depressed

Axis II: none known

Axis III: incarceration

Axis V: 50

Problem #1 depressed mood - in remission

Goal: maintain stability

Target Date for Resolution: 09/20/06

Intervention: counseling to monitor status of client

Staff Member Responsible: MN counselor

Frequency: monthly

Problem #2 low energy

Goal: increase energy level

Target Date for Resolution: _____

Intervention: counseling to help client increase energy level

Staff Member Responsible: MN counselor

Frequency: monthly

Problem #3 poor concentration

Goal: improve concentration

Target Date for Resolution: _____

Intervention: counseling utilizing cognitive behavioral therapy

Staff Member Responsible: MN counselor

Frequency: monthly

Psychiatrist: _____

Mental Health Nurse: _____

Treatment Coordinator: _____

Second Page attached: Yes ☐ No ☐

Treatment Team Members

Date: _____

Date: _____

Date: _____

Inmate Agreement: _____

Treatment Plan Review to be Conducted by: _____

Date: _____

(within six months)

Inmate Name: MAN BOE, name

AS #: 167435



Physician's Chronic Care Clinic

Date: 5/9/05 Time: 9:35 Facility: ElmoreCheck all applicable CICs being evaluated: Card/HTN DM GI ID PUL SZ TBOBJECTIVE: BP 122/86 HR 62 RR 18 Temp 97.8 Wt 193 Peak Flow 0250-98%

NOTE: PE findings for CIC patients should be disease-specific and focused on prevention of end-organ
 Complications: DM-eye ground, skin, cardiopulmonary, extremities; HTN/Card-eye grounds,
 Cardiopulmonary, abdomen, extremities; ID-all systems; PUL-HEENT,
 Cardiopulmonary, A/P ratio; SZ-HEENT, neurological; GI-abdomen.

Has completed tx
 Oc CC

no problems noted

ASSESSMENT: Circle the appropriate Degree of Control and Status for each clinic monitored during today's
 Visit. Degree of Control: G=Good, F=Fair, P=Poor
 Status: I=Improved, S=Stable, W=Worsened

DM			HTN/CARD			SZ			PUL			ID			GI			OTHER		
Degree of Control			Degree of Control			Degree of Control			Degree of Control			Degree of Control			Degree of Control			Degree of Control		
G	F	P	G	F	P	G	F	P	G	F	P	G	F	P	G	F	P	G	F	P
Status			Status			Status			Status			Status			Status			Status		
I	S	W	I	S	W	I	S	W	I	S	W	I	S	W	I	S	W	I	S	W

PLAN:

F/U: Routine 90 days: _____

Other: _____

Physician _____ MD

Problem List updated: Yes No

(01/31/05)

INMATE NAME

ONROE, James

NUMBER

167435

AGE

27

RACE/SEX

RI

SIGNATURE:

[Signature]

PRISON HEALTH SERVICES

Name: _____
 Inmate #: _____
 DOB: _____ Race: _____ Gender: _____

Nurse's Chronic Care Clinic

Date: 4/29/05 Time: 1444PM Facility: Elmore

Check all applicable CICs being evaluated: Card/HTN DM GI ID PUL SZ ✓TB

SUBJECTIVE:

For diabetic patients, list the # of hypoglycemic reactions since the last CIC visit: _____ Dates: _____
 See attached for monofilament check.
 For asthma patients, list the # of asthma attack visits since the last CIC visit: _____ Dates: _____
 For seizure patients, list the # of witnessed seizures since the last CIC visits: _____ Dates: _____

ALLERGIES: NKA CURRENT DIET: Regular

DESCRIBE MED AND DIET ADHERANCE: Therapy Completed

DESCRIBE ANY MED SIDE EFFECTS: _____

VACCINES: Flu _____ Pneumovax _____ Hep A _____ Hep B _____

For asthma pts, list the number of short-acting inhaler canisters refilled in the past month. _____
 (*This should equate to one inhaler per month.)

Lab/Diagnostic test(s) w/ date(s): HbA1c _____ on _____; CD4 & HIV-RNA _____ / _____ on _____;
 Peak Flow _____; LFTs _____ on _____; Serum Drug Levels _____ on _____; EKG _____; CXR _____;

AST _____ ALT _____
 MEDICATIONS: None

Therapy completed

OBJECTIVE:

WT 203 T 97° HR 75 R 20 O₂ Sats 97% / 0

B/P 130/84

Patient Educated on:

Therapy Completed

Inmate Signature X [Signature]

Nurses Signature and Title [Signature]

INMATE NAME	NUMBER	AGE	RACE/SEX
<u>Monroe, James</u>	<u>1167435</u>	<u>37</u>	<u>BM</u>

(01/31/05)

PRISON HEALTH SERVICES

Name: Monroe, James
 Inmate #: 1167435
 DOB: 9-8-67 Race: B Gender: M

Nurse's Chronic Care Clinic

Date: 3.31.05 Time: 10:02 Facility: KCF

Check all applicable CICs being evaluated: Card/HTN DM GI ID PUL SZ TB

SUBJECTIVE:

For diabetic patients, list the # of hypoglycemic reactions since the last CIC visit: Dates:
 See attached for monofilament check.

For asthma patients, list the # of asthma attack visits since the last CIC visit: Dates:

For seizure patients, list the # of witnessed seizures since the last CIC visits: Dates:

ALLERGIES: none CURRENT DIET: Reg

DESCRIBE MED AND DIET ADHERANCE: good

DESCRIBE ANY MED SIDE EFFECTS: none

VACCINES: Flu + Pneumovax + Hep A + Hep B +

For asthma pts, list the number of short-acting inhaler canisters refilled in the past month. 0
 (*This should equate to one inhaler per month.)

Lab/Diagnostic test(s) w/ date(s): HbA1c on : CD4 & HIV-RNA 1 on :
 Peak Flow : LFTs UNL on 3.9.05; Serum Drug Levels on ; EKG 4.05; CXR 3.05

MEDICATIONS:

INH 30mg
B6 25mg } x 31 days
 } from 3.8.05

Bp 120/84
 HR 88
 R 10
 T 99.2
 Wt. 161.5

Patient Educated on:

Facts About TB

Inmate Signature James Monroe

Nurses Signature and Title O. Shuffin RN

(01/31/05)



INTAKE HEALTH EVALUATION

NAME: Monroe, James
 AIS #: 167435
 D.O.B.: 9-8-67

Age 37 Sex m Race B Height 5'9 Weight 202

Temp: 98.3 B/P: 100/70 Pulse: 76 Resp: 18

** B/P - If greater than 140/90, repeat in 1 hour. Refer to Mid-Level if B/P remains up.

Do you now or have you ever had, or been treated for:

75BS-124mg/dl

Problem	Y	N	Problem	Y	N	Problem	Y	N
Head Trauma		<input checked="" type="checkbox"/>	Gastritis		<input checked="" type="checkbox"/>	HIV/AIDS ***		<input checked="" type="checkbox"/>
Loss of Consciousness		<input checked="" type="checkbox"/>	Ulcers		<input checked="" type="checkbox"/>	***Medications Verified		<input checked="" type="checkbox"/>
Severe Headaches		<input checked="" type="checkbox"/>	Bleeding		<input checked="" type="checkbox"/>	Hepatitis - Type		<input checked="" type="checkbox"/>
Vertigo/Dizziness		<input checked="" type="checkbox"/>	Gall Bladder/Pancreas		<input checked="" type="checkbox"/>	Gonorrhea		<input checked="" type="checkbox"/>
Vision Problems		<input checked="" type="checkbox"/>	Liver Problems		<input checked="" type="checkbox"/>	Syphilis		<input checked="" type="checkbox"/>
Hearing Problems		<input checked="" type="checkbox"/>	Arthritis		<input checked="" type="checkbox"/>	Lice, Crabs, Scabies		<input checked="" type="checkbox"/>
Seizures		<input checked="" type="checkbox"/>	Joint Muscle Problem		<input checked="" type="checkbox"/>			
Strokes		<input checked="" type="checkbox"/>	Back/Neck Problem		<input checked="" type="checkbox"/>	LMP		
Nervous Disorders		<input checked="" type="checkbox"/>	Kidney Stones/Dz		<input checked="" type="checkbox"/>	Date		
DT's		<input checked="" type="checkbox"/>	Bladder/Kidney Infection		<input checked="" type="checkbox"/>	Duration		
Heart Condition		<input checked="" type="checkbox"/>	Alcoholism		<input checked="" type="checkbox"/>	Normal		
Angina/Heart Attack		<input checked="" type="checkbox"/>	Drug Abuse		<input checked="" type="checkbox"/>	Regularity		
High Blood Pressure		<input checked="" type="checkbox"/>	Psychiatric History		<input checked="" type="checkbox"/>	Gravida/Para		
Anemia/Blood Disorder		<input checked="" type="checkbox"/>	Suicidal Thoughts**		<input checked="" type="checkbox"/>	AB/Miscarriage		
Sickle Cell or Trait		<input checked="" type="checkbox"/>	**Immediate M.H. Referral		<input checked="" type="checkbox"/>	Contraception		
Lung Condition		<input checked="" type="checkbox"/>	T.B.		<input checked="" type="checkbox"/>	Type:		
Asthma *		<input checked="" type="checkbox"/>	PPD - date given:		<input checked="" type="checkbox"/>			
*Peak Flow Reading		<input checked="" type="checkbox"/>	RFA/LFA		<input checked="" type="checkbox"/>	Lab Tests - Dates	N	Ab
Bronchitis		<input checked="" type="checkbox"/>	Date read:		<input checked="" type="checkbox"/>	Diagnostic Profile II		
Emphysema		<input checked="" type="checkbox"/>	Results: mm		<input checked="" type="checkbox"/>	RPR		
Pneumonia		<input checked="" type="checkbox"/>	Visual Acuity		<input checked="" type="checkbox"/>	Urine Dip Stick		
Diabetes		<input checked="" type="checkbox"/>	OD OS		<input checked="" type="checkbox"/>			
Hay Fever/Allergies		<input checked="" type="checkbox"/>	OU <u>20/20</u>		<input checked="" type="checkbox"/>	EKG (@ age 35)		

Immunization History: Td >10yrs

Immunizations Needed: Td 0.5cc @ delta

Lot U1212BA
 Tetanus and Diphtheria Toxoids Adsorbed
 For Adult Use, DECAVAC™
 US Govt Lic #1277
 Mfd by: Aventis Pasteur Inc.
 Swiftwater PA 15370 USA
 CPT® Code: 90718

0.5 mL

Rx only

4934

***HIV Medications:

Acute or Chronic Problem Noted: Y N

Refer to Mid-Level or M.D. if yes.

RN or Mid-Level, Signature M. Watson

Date/Time 03/07/05 1415

I have read the *access to health care* information sheets and have been given a copy. I understand how to access health care.

Name James Menroe Date 3-7-05

AIS# 167435

Medical Staff Mardy, MD Date 3-7-05



PRISON
HEALTH
SERVICES
INCORPORATED

T.B. SCREENING FORM

Skin Test Positive Date 8-4-04 14 mm Today's Date 3-7-05

Any Symptoms of:

Yes

No

Loss of Appetite

✓

Fever/Chills

✓

Hoarseness

✓

Chest Pain

✓

Weight Loss

✓

Usual Weight 186 lbs
Present Weight 202 lbs

Night Sweats

✓

Excessive Fatigue

✓

Dyspnea

✓

Productive Cough (more than 3 weeks)

✓

IF YES:

Sputum Production NA Color _____

Consistency _____

Hemoptysis NA

HIV Positive _____

Nurse Signature M. Hardy, RN Date 3-7-05

*Refer to MD or Mid-Level Provider if any YES answers.

INMATE NAME	AIS #	D.O.B.	FACILITY
Monroe, James	167435	9-8-67	KCF



PRISON
HEALTH
SERVICES
INCORPORATED

INTAKE SCREENING

Date: 03/04/05 AIS#: 167435

Last Name: Monroe First: James Middle: Kelly
Birthplace: Tuscaloosa Co. Jail DOB: 9-8-67 SS#: 418-94-4089

FEMALES: Pregnancy test: (circle one) Positive Negative B/P 139/76 Temp 99.1 Pulse 86 Resp 16 Weight 202
FSBS _____ If level > 200, repeat within 48 hours. Above 300 call M.D.

Previous Hospitalizations/Surgeries/Major Illness/Current Illness: What? Where?
Shoulder from dislocation - had surgery 1989

Previous Incarcerations (Date & Facility)
1991 KCF to Frank Lee - EOS/ Home
1994 KCF - Ballock to Eastfield to A+more back to Ballock 1998 KCF EOS 2003

Medications: ☐ None Finishing INH - March last month Special Diet (Prescribed) ☐ 0
Allergies: ANKA Past Positive TB Skin Test (circle one) YES - (Complete TB Screening Form) NO

ANY INMATE WHO IS UNCONSCIOUS, SEMICONSCIOUS, ACTIVELY BLEEDING, IN ACUTE PAIN AND URGENTLY IN NEED OF MEDICAL ATTENTION SHOULD IMMEDIATELY BE REFERRED FOR EMERGENCY CARE.

CLINICAL OBSERVATIONS

1) Level of Consciousness: <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Oriented; time, place, person <input type="checkbox"/> Lethargic <input type="checkbox"/> Stuporous <input type="checkbox"/> Comatose Describe: _____		3) Substance Abuse: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Suspected <input type="checkbox"/> Current intoxication/Abuse <input checked="" type="checkbox"/> Use <input type="checkbox"/> Withdrawal Symptoms <input checked="" type="checkbox"/> Drugs <input checked="" type="checkbox"/> Alcohol Describe: What kind? Amount/Frequency? <u>ETOH - few beers/day</u> <u>Drugs - marijuana</u> • If confirmed Benzo use, then call M.D. If can not be confirmed, call M.D. Last Use: (Time/Date): _____	
2) General Appearance <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal 3) Signs of Trauma <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		4b) Affect/Mood: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Manic <input type="checkbox"/> Depressed <input type="checkbox"/> Euphoria <input type="checkbox"/> Flat <input type="checkbox"/> Emotionally Confused Describe: _____	
4a) Behavior/Conduct: <input checked="" type="checkbox"/> Calm <input checked="" type="checkbox"/> Cooperative <input checked="" type="checkbox"/> Non-Violent <input type="checkbox"/> Agitated <input type="checkbox"/> Uncooperative <input type="checkbox"/> Violent <input type="checkbox"/> Manipulative <input type="checkbox"/> Disorganized Describe: _____		4c) Perceptions: <u>None</u> <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Hearing Voices 5a) Is there h/o actual suicide attempt? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 5b) Does pt describe current suicidal thoughts or ideations? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 5c) Is there evidence <u>NO</u> 5d) High risk pt may become assaultive towards staff? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
If ANY of the above in #5 are circled, staff MUST describe here, include previous history and dates: *Any abnormal observations #4 or 5 require immediate Mental Health Referral.		Triggers for Suicide Watch - Currently Suicidal - History of actual attempt - Fails to maintain control on Close Watch Y or N Triggers for Close Watch - Emotionally distraught and unable to regain composure by end of intake process - Actively hallucinating or not making any sense Y or N	
6a) Communication Difficulties <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 6b) Memory Defects <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		6c) Hearing Impairment <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 6d) Speech Difficulties <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
7) Physical Aids: <input checked="" type="checkbox"/> None <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Dentures <input type="checkbox"/> Cane <input type="checkbox"/> Crutches <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Braces <input type="checkbox"/> Artificial Limb <input type="checkbox"/> Other			
8) Additional comments, complaints, symptoms: <u>None</u> <u>X</u> S) _____ O) Fever Y N Swollen Glands Y N Signs of Infection Y N Skin Intact Y N A) _____ P) _____			

If known Diabetic * Call M.D. for order _____ Initial Insulin given: _____

I have answered all questions truthfully. I have been told and shown how to obtain medical services. I hereby give my consent for health services to be provided to me by and through PRISON HEALTH SERVICES.

James K Monroe 3/4/05
Inmate's Signature/Date

Linda Bell 3/4/05
Health Provider Signature/Date

ALABAMA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES
REFERRAL TO MENTAL HEALTH

Inmate Name: JAMES MONROE AIS# 167435 Date of Referral: 9/13/06

REASON FOR REFERRAL:

CRISIS INTERVENTION

problem:

Family

Problems with other

inmates:

Recent

stress:

Other:

EVALUATION OF MENTAL STATUS

Suicidal

Homicidal

Mutilative

Hostile, angry

Other inappropriate behavior:

Anxious

Depressed

Withdrawn

Poor hygiene

Physical complaints

Sleep disturbance

Hallucinations/delusions

Suspicious

EVALUATION OF NEED FOR PSYCHIATRIC EVALUATION

HISTORY OF PSYCHOTROPIC MEDICATION PRIOR TO RECEPTION/TRANSFER

OTHER:

COMMENTS:

Coded M1-0 (Reports exaggerated startle response)
39, B/m serving fifteen years for multiple property cases

Referred by:

Carl D. Burns

Phone Contact #:

567-1564

Referral for psychiatrist (referral has been screened by mental health or medical staff)

MENTAL HEALTH FOLLOW-UP: EVALUATION/TREATMENT/DISPOSITION

Mr. Burns: Seen 9/21/06

Met 2 inmate, he stated "just wanted to talk to somebody. I'm fine. I don't want any meds."
Follow-up will be provided on PRN basis.

Follow-Up by:

Dr. Santana

Date:

9/25/06

Inmate Name

MONROE, JAMES

AIS #

167435

ALDOC Form 452-03

DATE:	TIME:	Behavioral Rating Scale 0=No problem 5= worst	Today vs Before
9/26/06			
Target Symptoms			
"Stressed out"			0-1 / 0-1
Depressed mood			0 / 0
Low energy			0-1 / 0-1
Paranoid ideas			0 / 0
Difficulty adjusting/Coping			0-1 / 0-1
Medications:			Informed Consent
Im is not on any psychotropic meds.			
Compliance:	Inmate report	% vs. MAR	
In addition to the information in the tables above and below, then inmate patient:			
S "I was doing so good. That guy stabbed me at the back for nothing. I still hurt because of that. I am little fearful. I need someone to talk to. I don't want any medicines. I may go for work release soon." Reports of other Sxs of mood/anxiety or thought d/o. & thoughts to hurt			
Side effects			
Selected Issues	NO	YES	If yes, comment on pertinent positive findings
Psychosis	<input checked="" type="checkbox"/>		Ph SI, Ph AI, Ph AA, & delusions, & paranoia.
Severe Depression	<input checked="" type="checkbox"/>		mild Sxs of situational depression noted
Self-Injurious Thoughts	<input checked="" type="checkbox"/>		Denies
Suicidal intent	<input checked="" type="checkbox"/>		Denies
Aggressive	<input checked="" type="checkbox"/>		None noted / at
Seriously Injurious	<input checked="" type="checkbox"/>		None noted / present time
Situational Upset	<input checked="" type="checkbox"/>		Re: current stress of being stabbed
Lab info:	Lab Ordered:	Lab Reviewed:	AMS:V
None at this time from mental health. another Im in recent past.			
ASSESSMENT/Diagnosis (DSM-IV)			
Adjustment D/o & Depressed Mood (in remission) so no.			
PLAN: Im clinically stable. Im is not on any psychotropic meds. Refusing all psychotropic meds. At present time. He wants to get counseling from mental health due to his recent stress from being stabbed			
Return to Clinic:	Print Last Name	Signature	
RTC 90 days	DR. BANERJEE	SBanerjee, MD.	
Patient's Name: (Last, First, Middle)	AIS #	Age	R/S
MONROE, JAMES	167435		B/M
Code	Institution		
MH-9	STATON		
Disposition: Medical File			
ADOC AR 632, 633, 623, 615			
ADOC Form MH-025 March 2, 2005			
another Im in recent past. Will keep him on mental health caseload at present time. Continue care. RTC in 90 days for follow up.			
logical & assoc notes			



SPECIAL NEEDS COMMUNICATION FORM

Date: 6/8/06To: Mr. Dennis - Shift OfficeFrom: Dr. SantanaInmate Name: JAMES MONROE ID#: 167435

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions NO FARM DUTY
4. May have extra _____ until _____
5. Other _____

Comments:

Inmate is motivated and prepared to work, however, due to Sx of mental illness & phobia related to being around guns & different types of potential weapons. Phobias places the individual at risk of escaping what is feared.

Date: 6/8/06 MD Signature: Dr. Santana Time: 11:40

Please assign a different type of job with no potential weapons (NO Kitchen duty please).

PSYCH RIC PROGRESS NOTES

DATE:	TIME:	Behavioral Rating Scale 0=No problem 5= worst	Today vs Before
6/27/06			
Depressed mood			0/0
Low energy			0/0
Poor concentration			0/0
Unable to cope			0/0
Difficulty adjusting			0/0
Medications:			Informed Consent
Phozac D/c'd 2/3/06. Im doing well clinically.			
Compliance:	Inmate report	% vs MAX	%

In addition to the information in the tables above and below, then inmate-patient:

S^{cc} I am great. I am doing real good. I just need some sleep medicine to help me rest. I am doing good. Reports of other Sx's of mood, anxiety &c. Thought d/c. & thoughts to hurt himself or anyone else. Voices no other concerns. A to P 3. Mood - euthymic; Affect: Appropriate

Selected Issues	NO	YES	If yes, comment on pertinent positive findings
Psychosis	L		of SE, of HE, of HA, of delusions, of paranoia
Serious Depression	L		of Sx's of depression noted at this time.
Self-Injurious Thoughts	L		Denies
Suicidal intent	L		Denies
Aggressive	L		None noted
Seriously Impulsive	L		None noted at present time
Situational Upset	L		None noted

Thought Process: logical, & loose associate noted.

Life Info: None at this time from mental health.

ASSESSMENT/Diagnosis (DSM-IV)

Adjustment D/c Depressed Mood
(in remission)

PLAN: Im clinically stable. Doing well without being on any psychotropic meds. since 2/3/06. Exhibits no signs of mental illness at present time. Discuss

c TX team to change his mental health code to zero. This time

Patient's Name: (Last, First, Middle)		AS#	Age	R/S	Code	Institution
MONROE, JAMES		167435		B/M	MH=0	STATON

Disposition: Medical File

Discussed TX plan & Im - He understands and agrees & TX plan. Rtc RTC on PRN basis at this time.

ALABAMA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES
PSYCHIATRIC PROGRESS NOTES

DATE: 2/3/06	TIME:	Today vs Before
Target Symptoms	Behavioral Rating Scale 0=No problem 5= worst	
Depressed mood		0 / 1
Low energy		0 / 1
Poor concentration		0 / 0-1
Unable to cope		0 / 1-2
Difficulty adjusting		0 / 2
Medications:	Prozac	Informed Consent
100% med non-compliant	Dlc'd as of 2/3/06.	
Compliance: Inmate report	% vs MAR	%

In addition to the information in the tables above and below, then inmate-patient:

S. or I am not taking medicine. I am fine. I don't want to take the medicine anymore. My mood is good. I am not depressed. Please take me off the medicine. I want to try it out on my own. Reports of other sxs of mood, anxiety or thought d/o. & thoughts to hurt himself or

Selected Issues	NO	YES	If yes, comment on pertinent positive findings
Psychosis	✓		anyone else. Vocals no other
Severe Depression	✓		Concer.
Self-Injurious Thoughts	✓		Atrox.
Suicidal intent	✓		Mood
Aggressive	✓		enthy.
Seriously Impulsive	✓		Affect
Situational Upset	✓		Approp

Lab info: None Labs Ordered: Labs Reviewed: AIMS:?

ASSESSMENT/Diagnosis (DSM-IV)

Adjustment D/o c Depressed Mood
(in remission)

PLAN: I'm clinically stable. Has been med non-compliant. Refusing all psychotropic meds at this time. Exhibits & sxs of signs of mental illness at present. Will Dlc Prozac Will be RTC 90 days

Patient's Name: (Last, First, Middle)	Print Last Name:	Signature:	Code	Institution
MONROE, JAMES	DR. BANNERSEE	Stamenjee, MD	B/M, SMI	ELMORE

Disposition: Medical File followed up 2 counseling
RTC 90 days for follow up. Cont. med. care.

DATE	TIME	NOTES	SIGNATURE
9/21/06	10:00	<p>(S) "I've been feeling paranoid ever since I got stabbed. I didn't even know the guy & he just stabbed me in the back. I almost died from all the bleeding. They are going to get a lawsuit from this."</p> <p>(O) Slightly agitated mood & affect. needing constant reassurance! Thought process logical & goal directed; cleared A/H; feels paranoid & stressed over the stabbing; mild Sxs of acute stress D/O.</p> <p>(P) Verdict is not on meds. at this time. He's experiencing some mild Sxs of acute stress D/O.</p> <p>(P) Will continue f/p. PRN basis.</p> <p style="text-align: right;">Theresa Taus, Psy.D.</p>	
10/23/06	10:50	<p>(S) "I'm paranoid all the time. But I don't want any medication. I'm dealing w it. No other complaints voiced at this time."</p> <p>(O) agitated mood & affect. Thoughts were logical; no loose assoc; no delusions. cooperative.</p> <p>(P) Verdict is stable at this time. He is trying to adjust to the recent situation in his life. No meds at this time.</p> <p>(P) Continue f/p.</p> <p style="text-align: right;">Theresa Taus, Psy.D.</p>	

Patient's Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
Monroe, James			B/M	SCF

Patient's Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
Monroe, James	167435		B /M	Stabo

INT DISCIPLINARY PROGRESS NO 5

DATE	TIME	NOTES	SIGNATURE
3-17-06	9:50	<p>met with client for monthly session. down line said he did pretty good in the last 30 days but they want him to do four more months said it's not right. he will not do it. not taking any medication. Got a glycolytic. they will stop him. said it will be alright.</p> <p>O: smiling, laughed, polite, appropriate mood.</p> <p>A: no sign of depression.</p> <p>P: continue to court.</p>	MS
4/12/06	10:30AM	<p>(S) I'm fine. I don't need medicine. I never took the medication. I was just a bit stressed out due to family problems, but I got it straightened out.</p> <p>(O) appropriate mood & affect. plenty of speech. no evidence of psychosis. cooperative. thoughts were logical.</p> <p>(A) client's meds. were sc'd back in February, 06. He stated never being compliant as he feels he didn't need meds. to begin with.</p> <p>(P) A code to (M#-0).</p>	<p>Wendy Smith</p> <p>Theresa Tamm, Psy.D</p>

Patient's Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
Moore, James	167435		B M	Clmore

DATE	TIME	NOTES	SIGNATURE
1/19/06	9:30a	<p>S "I'm having problems with my bladder."</p> <p>O A to X3. Normal mood & affect. No sign of depression or anxiety. Denied HI/SI, no AIV hallucinations. Eye contact good, insight: fair, judgement: fair. No reported sleep or appetite disturbance. Inmate discussed his medical problem. MHP informed inmate to sign up for sick call. Discussed coping skills with inmate. No other complaints voiced, stable at present.</p> <p>A AX is I: Adv P to Depressed mood</p> <p>P Continue care.</p> <p>K Jones, MS, MHP</p>	
2/23/06	9:15am	<p>S: met w. the client for monthly service. Said he is doing well, ready to go home to his wife and children, not taking any medication, reads the bible, no problems.</p> <p>O: polite, verbalized well, logical thought, mood appropriate. No signs of depression.</p> <p>D: Continue to counsel.</p> <p><i>[Signature]</i></p>	

Patient's Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
Monroe James	167435		B/M	Genove

DATE: 12/20/05	TIME:
Target Symptoms	Behavioral Rating Scale 0=No problem 5= worst
Depressed mood	1/0-1
Low energy	1/0-1
Poor concentration	0-1/0-1
Unable to cope	1-2/1-2
Difficulty adjusting	2/2
Medications: got started on Prozac.	Informed Consent
Compliance: Inmate report % vs MAR %	✓

In addition to the information in the tables above and below, then inmate-patient:

S "I am having difficulty adjusting to this camp. I feel sad at times. I don't know how ~~I~~ well I be able to deal with my sentence here." Reports of other sxs of mood, anxiety or thought d/o. & thoughts to hurt himself or anyone else. Voices no other concerns

Selected Issues	NO	YES	If yes, comment on pertinent positive findings
Psychosis	✓		at present time. A+ x3.
Serious Depression	✓		of sxs of psychosis, of SI, of HI, of HA
Self-Injurious Thoughts	✓		of sxs of anxiety, of sxs of delusion
Suicidal intent	✓		Denies
Aggressive	✓		Denies
Seriously Impulsive	✓		None noted
Situational Upset	✓		None noted / at present time

Lab info:	Lab Ordered:	Lab Reviewed:	AMS?
None	from mental health at this time		

ASSESSMENT/Diagnosis (DSM-IV)
Adjustment D/o & Depressed mood.

PLAN: Im exhibits mild sxs of Depression will start him on Prozac 20 mg/d. Discussed risks/benefits of being on Prozac & Im. He understands and agrees to Tx plan. Continue

Return to clinic: R/C 90 days	Print Last Name: DR. BANERJEE	Sign: Banerjee, MD
Patient's Name: (Last, First, Middle)	Age	R/S
MONROE, JAMES	167435	B/M
Code	Institution	
SMI	ELMORE	

Disposition: Medical File

ADOC AR 632, 633, 623, 615
ADOC Form MH-025 March 2, 2005

Mood: Somewhat sad mood noted at time
Affect: mild health depressed affect noted occasion
Thought: Prozac logical & pros
associations noted

ALABAMA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES
RECEPTION MENTAL HEALTH SCREENING

Institution: KILBY

Date/Time Inmate Received: 3-4-05

Date/Time of Screening: 3/7/05

Signature/Title of Screener: MS. L. Henderson LPN

MENTAL HEALTH TREATMENT PRIOR TO ENTERING THE ADOC

- ☐ Yes ☒ No Psychotropic medication: _____
☐ Yes ☒ No Medication turned over to ADOC upon arrival?
☐ Yes ☒ No Mental health follow-up in last 90 days: _____
☐ Yes ☒ No Suicide/self-harm attempts in last 90 days: _____

MENTAL HEALTH HISTORY Does inmate report a history of the following (if yes, provide details):

- ☐ Yes ☒ No Outpatient treatment: _____
☐ Yes ☒ No Inpatient treatment: _____
☐ Yes ☒ No Psychotropic medication: _____
☐ Yes ☒ No Suicidal attempts: _____
☐ Yes ☒ No Suicidal thoughts: _____
☐ Yes ☒ No Head injury: _____
☐ Yes ☒ No Seizures: _____
☐ Yes ☒ No Violent behavior: _____
☒ Yes ☒ No Substance abuse: MT 1998
☒ Yes ☒ No Substance abuse treatment: SAP-2012
☒ Yes ☒ No Special education classes: CMP 2012-2015

INMATE SELF-REPORT OF CURRENT STATUS

- ☐ Yes ☒ No First incarceration (reaction): ✓ 11/12
☐ Yes ☒ No Reports family support: wife
☐ Yes ☒ No Reports serious depression/nervousness: don't know ha
☐ Yes ☒ No Thinking about suicide: I feel I don't want
☐ Yes ☒ No Has plan for suicide: be here
☐ Yes ☒ No Possible to implement plan: _____
☐ Yes ☒ No Reports hallucinations: _____

BEHAVIORAL OBSERVATIONS

- ☐ Poor eye contact ☐ Poor hygiene ☐ Unable to pay attention ☐ Unresponsive
☐ Disoriented ☐ Overly anxious ☐ Unable to follow directions ☐ Unable to read
☐ Crying ☐ Memory deficits ☐ Signs of self-mutilation ☐ Afraid
☐ Illogical speech content ☐ Appears to be hearing voices or seeing things ☐ Paranoid
☐ Hostile ☐ Other unusual behavior: _____

DISPOSITION/ PLACEMENT RECOMMENDATION (based on reception mental health screening)

- ☐ Routine housing and mental health follow-up ☐ Emergency mental health referral
☐ Priority mental health follow-up but not emergency ☐ Safe cell placement recommended
☐ Current psychotropic meds verified/interim supply ordered ☐ Parole violator interim assessment referral

Inmate Name	Monroe, James	AIS #	1674350
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more

Sep. 12, 2006 3:00PM

From: b18139

Pages: 25 (including banner)

IMNET/EPRS print request.

DOB: 09/09/81

Admit Date/Time: 08/04/05

815 FALERO, WALLACE C

MONROE JAMES

Age: 38Y MR #: 709779

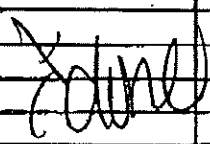


2151P



Baptist

AERAS PHYSICIAN ORDER SHEET

Patient Information

Date/Time		TEST		SYMPTOMS	
PROCEDURE SET-UPS					
<input type="checkbox"/> Visual Acuity					
<input type="checkbox"/> Eye Box	<input type="checkbox"/> Morgan Lens	<input type="checkbox"/> Corneal Burr	<input type="checkbox"/> Dacriose		
	<input type="checkbox"/> Tetracaine	<input type="checkbox"/> Tonnen	<input type="checkbox"/> Woods Lamp		
<input type="checkbox"/> Nose Tray	<input type="checkbox"/> Head Light				
<input type="checkbox"/> Dental Box					
<input type="checkbox"/> Ortho Box					
<input type="checkbox"/> Pelvic Exam					
<input type="checkbox"/> Lumbar Puncture					
<input type="checkbox"/> NG-Tube					
<input type="checkbox"/> Splint					
<input type="checkbox"/> Crutch Walking					
<input type="checkbox"/> Suture Set-Up					
BEHAVIORAL HEALTH					
<input type="checkbox"/> Psychiatric Evaluation/Screening					
<input type="checkbox"/> Restraints	See Restraint Order/Sheet				<input type="checkbox"/> 1:1 Seclusion
IV FLUIDS					
<input type="checkbox"/> IV Site _ x1 _ x2					
<input type="checkbox"/> IV Bolus	<input type="checkbox"/> _____ X500ml	<input type="checkbox"/> _____ 1 Liter	<input type="checkbox"/> _____ 2 Liters		
<input type="checkbox"/> IV Fluids	_____ at _____ ml/hr	_____ at _____ ml/hr	_____ at _____ ml/hr		
<input type="checkbox"/> IV Critical Drips	Cardizem	Nitroglycerin	Dopamine		
	Nipride	Integrilin	Other		
TIME	MEDICATIONS		TIME	MEDICATIONS	
2150	PO Risperidone PO Morphine 4mg PO Zofen 4mg 				
TIME	CONSULTS			<input type="checkbox"/> See additional medication order form.	
<input type="checkbox"/> Primary Physician Time Notified		<input type="checkbox"/> On-Call Specialist Time Notified		<input type="checkbox"/> GMS/FMS/Hospitalist Time Notified	
Time Responded		Time Responded		Time Responded	
DISPOSITION					
TIME	DISCHARGE	ADMISSION	TRANSFER	EXPIRED	
	<input type="checkbox"/> Home	<input type="checkbox"/> Regular Room # _____	<input type="checkbox"/> Hospital	<input type="checkbox"/> Coroner Called	
	<input type="checkbox"/> AMA signed unsigned	<input type="checkbox"/> Telemetry Room # _____	<input type="checkbox"/> Psychiatric/Meadhaven	<input type="checkbox"/> Death Certificate Signed	
	<input type="checkbox"/> Elopement	<input type="checkbox"/> Observation Room # _____	<input type="checkbox"/> Other		
	<input type="checkbox"/> LBMSE	<input type="checkbox"/> Surgery			
	<input type="checkbox"/> Work/School Excuse Provided x's _____ Days		<input type="checkbox"/> Workers Comp Papers Initiated		
PHYSICIAN SIGNATURE:			EXTENDER SIGNATURE:		
					
Certified Medical Emergency <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			Dictation		



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PAGE 4 OF 4 Form #ER 16005 Revised 06/01/06

PRINTED BY: b18139

DATE 9/12/2006

No. 2588-P. 10/24

Sep. 12. 2006 3:02PM



BD624700398 MONROE, JAMES
 DOB: 09/08/67 Age: 38Y MR #: 709779
 Admit Date/Time: 09/04/06 2151P
 915 PALERO, WALLACE G



AERAS PHYSICIAN ORDER SHEET

Date/Time	TEST	SYMPTOMS			
RADIOLOGY					
	<input type="checkbox"/> CT <input type="checkbox"/> C-Spine <input type="checkbox"/> T-Spine <input type="checkbox"/> L-Spine	<input type="checkbox"/> Abnormal gait <input type="checkbox"/> Abnormal involuntary movement <input type="checkbox"/> Lack of Coordination <input type="checkbox"/> Osteomyelitis	<input type="checkbox"/> Meningitis <input type="checkbox"/> Neoplasm <input type="checkbox"/> Pain <input type="checkbox"/> Spina bilida <input type="checkbox"/> Transient paralysis limb	<input type="checkbox"/> Injuries related to MVC <input type="checkbox"/> GSW <input type="checkbox"/> Stabbing <input type="checkbox"/> Other	
2/6/06	<input checked="" type="checkbox"/> CT AngioChest <input checked="" type="checkbox"/> With IV Only	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Hemoptysis <input type="checkbox"/> SOB	<input type="checkbox"/> Tachypnea <input type="checkbox"/> Other		
	<input type="checkbox"/> CT Pelvis Abdomen <input type="checkbox"/> Without Contrast <input type="checkbox"/> Oral Contrast <input type="checkbox"/> IV Contrast <input type="checkbox"/> Rectal Contrast <input type="checkbox"/> Stone Search <input type="checkbox"/> Appendicitis Protocol <input type="checkbox"/> Diverticulitis Protocol	<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Abdominal Rigidity <input type="checkbox"/> Abdominal Swelling <input type="checkbox"/> Abdominal Tenderness <input type="checkbox"/> Aneurysm <input type="checkbox"/> Ascites <input type="checkbox"/> Blunt/Penetrating Trauma <input type="checkbox"/> Edema <input type="checkbox"/> Extravasation of Urine <input type="checkbox"/> Fever <input type="checkbox"/> Hepatomegaly/Splenomegaly	<input type="checkbox"/> Injury to Blood Vessels <input type="checkbox"/> Infection, Post Op <input type="checkbox"/> Internal Injury (Thorax, <input type="checkbox"/> Abdomen & Pelvis) <input type="checkbox"/> Liver Disease <input type="checkbox"/> Renal Colic	<input type="checkbox"/> Other	
	<input type="checkbox"/> CT Other				
	<input type="checkbox"/> MRI of				
	<input type="checkbox"/> Ultrasound <input type="checkbox"/> Complete Abdomen <input type="checkbox"/> RUO(GB) <input type="checkbox"/> Pelvic <input type="checkbox"/> Obstetrical	<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Abdominal Tenderness <input type="checkbox"/> Abnormal X-ray <input type="checkbox"/> Ascites <input type="checkbox"/> Abdominal Swelling <input type="checkbox"/> Abdominal Mass	<input type="checkbox"/> Colic <input type="checkbox"/> Flank Mass <input type="checkbox"/> Flank Pain <input type="checkbox"/> Flank Tenderness <input type="checkbox"/> Hepatomegaly/Splenomegaly	<input type="checkbox"/> Pelvic Pain <input type="checkbox"/> Pelvic Mass <input type="checkbox"/> Pelvic Tenderness <input type="checkbox"/> Spleen Mass <input type="checkbox"/> Other	
	<input type="checkbox"/> Doppler Series	<input type="checkbox"/> Erythema <input type="checkbox"/> Lower Extremity Pain	<input type="checkbox"/> Swelling <input type="checkbox"/> Tenderness	<input type="checkbox"/> Other	
CARDIOLOGY					
	<input type="checkbox"/> BP Both Arms				
	<input type="checkbox"/> Orthostatic VS				
	<input type="checkbox"/> Cardiac Monitor				
	<input type="checkbox"/> EKG				
	<input type="checkbox"/> Repeat EKG				
	<input type="checkbox"/> ECHO				
	<input type="checkbox"/> Cath Lab				
RESPIRATORY					
	<input type="checkbox"/> Pulse Oximetry				
	<input type="checkbox"/> Oxygen ___ L/min	<input type="checkbox"/> Cannula <input type="checkbox"/> Non-Rebreather Mask	<input type="checkbox"/> Non-Simple Mask		
	<input type="checkbox"/> Nebulizer	<input type="checkbox"/> Peak Flow <input type="checkbox"/> DuoNeb	<input type="checkbox"/> Albuterol <input type="checkbox"/> Atrovent	<input type="checkbox"/> Xopenex <input type="checkbox"/> Other	
	<input type="checkbox"/> Inhaler with spacer teaching				
	<input type="checkbox"/> C-PAP <input type="checkbox"/> Bi-PAP	<input type="checkbox"/> Vent Settings			
	<input type="checkbox"/> Central Line				
	<input type="checkbox"/> Chest Tube	<input type="checkbox"/> Right <input type="checkbox"/> Left			



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PAGE 3 OF 4 Form #ER 16005 Revised 06/01/06

PRINTED BY: b18139

DATE 9/12/2006



B0824700398 MONROE, JAMES
 DOB: 09/08/67 Age: 38Y MR R: 709779
 Admit Date/Time: 09/04/06 2151P
 915 FALERO, WALLACE G



AERAS PHYSICIAN ORDER SHEET

Date/Time	TEST	SYMPTOMS		
LABORATORY				
	<input type="checkbox"/> Troponin I	<input type="checkbox"/> Abnormal Electrocardiogram <input type="checkbox"/> ACS (Angina, Acute MI) <input type="checkbox"/> Apnea/SOB/Wheezing	<input type="checkbox"/> Arrhythmia/Tachycardia <input type="checkbox"/> Chest Pain <input type="checkbox"/> Injury to Thorax, Abdomen, Pelvis	<input type="checkbox"/> Respiratory Distress <input type="checkbox"/> Insufficiency <input type="checkbox"/> Other _____
	<input type="checkbox"/> Urinalysis <input type="checkbox"/> Clean Catch <input type="checkbox"/> Cath	<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diabetes <input type="checkbox"/> Dysuria <input type="checkbox"/> Edema <input type="checkbox"/> Fever	<input type="checkbox"/> Flank Pain <input type="checkbox"/> Hematuria <input type="checkbox"/> Hesitancy <input type="checkbox"/> Hypertension <input type="checkbox"/> Known Kidney Disease	<input type="checkbox"/> Long-term Medications <input type="checkbox"/> Nocturia <input type="checkbox"/> Pelvic Pain <input type="checkbox"/> Trauma to Kidney/Urinary Tract <input type="checkbox"/> Other _____
	<input type="checkbox"/> Foley Catheter	Record Output		
	<input type="checkbox"/> Blood Cultures	X's _____	<input type="checkbox"/> Fever	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Hemocult <input type="checkbox"/> Gastrocult	Other _____		
	<input type="checkbox"/> GC Chlamydia <input type="checkbox"/> Wet Prep	<input type="checkbox"/> Herpes	Other _____	Other _____
	<input type="checkbox"/> Urine Pregnancy <input type="checkbox"/> Serum Pregnancy	<input type="checkbox"/> Qualitative <input type="checkbox"/> Quantitative		
	<input type="checkbox"/> ETOH Level	<input type="checkbox"/> Urine Drug Screen <input type="checkbox"/> Serum Drug Screen	<input type="checkbox"/> Other Drug Level(s) _____	
	<input type="checkbox"/> Other Lab Tests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Type (Rh) <input type="checkbox"/> Type & Screen <input type="checkbox"/> Type & Cross	X's _____ Units	<input type="checkbox"/> Other Blood Products	
RADIOLOGY				
	X-ray <input type="checkbox"/> C-Spine <input type="checkbox"/> T-Spine <input type="checkbox"/> L-Spine	<input type="checkbox"/> Deformity <input type="checkbox"/> New Injury <input type="checkbox"/> Old Injury <input type="checkbox"/> Pain	<input type="checkbox"/> Trauma <input type="checkbox"/> Other _____	
<i>206</i>	X-ray <input checked="" type="checkbox"/> Chest <input type="checkbox"/> Portable <input type="checkbox"/> Standing PA/L	<input type="checkbox"/> Abnormal Sputum <input type="checkbox"/> Abnormal Weight Loss <input type="checkbox"/> Abnormal X-ray <input type="checkbox"/> Chest Pain <input type="checkbox"/> Clubbing of Fingers	<input type="checkbox"/> Cough <input type="checkbox"/> Cyanosis <input type="checkbox"/> Fever <input type="checkbox"/> Hemoptysis	<input type="checkbox"/> Palpitations <input type="checkbox"/> Respiratory Infection <input type="checkbox"/> Respiratory Distress <input type="checkbox"/> Shock <input type="checkbox"/> Other _____
	X-ray <input type="checkbox"/> Abdominal Series <input type="checkbox"/> KUB	<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Abdominal Rigidity <input type="checkbox"/> Abdominal Swelling <input type="checkbox"/> Abdominal Tenderness <input type="checkbox"/> Aneurysm <input type="checkbox"/> Ascites	<input type="checkbox"/> Blunt/Penetrating Trauma <input type="checkbox"/> Edema <input type="checkbox"/> Extravasation of Urine <input type="checkbox"/> Fever <input type="checkbox"/> Hepatomegaly/Splenomegaly <input type="checkbox"/> Injury to Blood Vessels	<input type="checkbox"/> Infection, Post Op <input type="checkbox"/> Internal Injury (Thorax) <input type="checkbox"/> Abdomen & Pelvis <input type="checkbox"/> Liver Disease <input type="checkbox"/> Renal Colic <input type="checkbox"/> Other _____
	X-ray Upper Extremity <input type="checkbox"/> R O L	<input type="checkbox"/> Deformity <input type="checkbox"/> New Injury <input type="checkbox"/> Old Injury <input type="checkbox"/> Pain	<input type="checkbox"/> Trauma <input type="checkbox"/> Other _____	
	X-ray Lower Extremity <input type="checkbox"/> R O L	<input type="checkbox"/> Deformity <input type="checkbox"/> New Injury <input type="checkbox"/> Old Injury <input type="checkbox"/> Pain	<input type="checkbox"/> Trauma <input type="checkbox"/> Other _____	
	<input type="checkbox"/> VQ Scan	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> SOB	<input type="checkbox"/> Other _____
	<input type="checkbox"/> CT Head/Brain <input type="checkbox"/> Without Contrast <input type="checkbox"/> With & Without	<input type="checkbox"/> Closed Head Injury (Concussion) <input type="checkbox"/> CVA/TIA <input type="checkbox"/> Delirium/Dementia <input type="checkbox"/> Headache (excluding Migraine)	<input type="checkbox"/> Occlusion of Artery <input type="checkbox"/> Penetrating Trauma <input type="checkbox"/> Seizure <input type="checkbox"/> Sinusitis (chronic) <input type="checkbox"/> Stroke	<input type="checkbox"/> Subarachnoid - Intracerebral Hemorrhage <input type="checkbox"/> Suspected Metastasis <input type="checkbox"/> Syncope/Collapse <input type="checkbox"/> Other _____



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DATE 9/12/2006

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B0624700398 MONROE, JAMES
 DOB: 09/08/67 Age: 38Y MR #: 709779
 Admit Date/Time: 09/04/06 2151P
 915 FALLER, WALLACE G



AERAS PHYSICIAN ORDER SHEET

Date/Time	TEST	SYMPTOMS	
	<input type="checkbox"/> 911 Trauma Panel	CBC Comprehensive Metabolic Troponin	Alcohol Urinalysis Pregnancy Test
	<input type="checkbox"/> 922 Trauma Panel	CBC Comprehensive Metabolic Troponin	Alcohol Urinalysis Pregnancy Test
	<input type="checkbox"/> 933 Trauma Panel	CBC Basic Metabolic Urinalysis	Pregnancy Test
	<input type="checkbox"/> ABG	<input type="checkbox"/> Acute Asthma <input type="checkbox"/> Acidosis <input type="checkbox"/> Alkalosis <input type="checkbox"/> Burns to Face <input type="checkbox"/> Cardiopulmonary Arrest <input type="checkbox"/> CHF	<input type="checkbox"/> COPD <input type="checkbox"/> Dyspnea (unexplained) <input type="checkbox"/> Hypoventilation <input type="checkbox"/> Morbid Obesity <input type="checkbox"/> Multiple Trauma <input type="checkbox"/> Noxious Gas Inhalation
	<input type="checkbox"/> AccuChek	<input type="checkbox"/> Decreased LOC <input type="checkbox"/> Hx of Diabetes/Hypoglycemia	<input type="checkbox"/> Pleural Effusion <input type="checkbox"/> Pneumonia <input type="checkbox"/> Pneumothorax <input type="checkbox"/> Pulmonary Embolus <input type="checkbox"/> Respiratory Distress <input type="checkbox"/> Other
	<input type="checkbox"/> Amylase <input type="checkbox"/> Lipase	<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diabetes <input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Other
	<input type="checkbox"/> BMP Basic Metabolic Panel	<input type="checkbox"/> Complications Related to <input type="checkbox"/> Pregnancy <input type="checkbox"/> Diabetes Complications <input type="checkbox"/> Dizziness/Giddiness <input type="checkbox"/> Drowsiness	<input type="checkbox"/> Edema <input type="checkbox"/> Febrile Convulsions <input type="checkbox"/> Glomerulonephritis <input type="checkbox"/> Hypertensive Disease
	<input type="checkbox"/> CMP Comprehensive Metabolic	<input type="checkbox"/> Acidosis <input type="checkbox"/> Alkalosis <input type="checkbox"/> CHF <input type="checkbox"/> Coma <input type="checkbox"/> Diabetes <input type="checkbox"/> Diarrhea	<input type="checkbox"/> Dehydration <input type="checkbox"/> Dizziness <input type="checkbox"/> Drowsiness <input type="checkbox"/> Edema/Ascites <input type="checkbox"/> Hypertension <input type="checkbox"/> Long-term Medication(s)
	<input type="checkbox"/> BNP	<input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Edema/Lower Extremities	<input type="checkbox"/> Pulmonary Edema <input type="checkbox"/> SOB
2760	<input checked="" type="checkbox"/> CBC	<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Abnormal Bleeding <input type="checkbox"/> Blood Loss - Hemorrhage <input type="checkbox"/> Chills <input type="checkbox"/> Epistaxis <input type="checkbox"/> Fatigue/Malaise <input type="checkbox"/> Flank Pain	<input type="checkbox"/> Infection <input type="checkbox"/> Hemoptysis <input type="checkbox"/> High Risk Medication(s) <input type="checkbox"/> Lethargy <input type="checkbox"/> Long-term Medications <input type="checkbox"/> Lymphadenopathy <input type="checkbox"/> Malnutrition
	<input type="checkbox"/> D-Dimer	<input type="checkbox"/> Erythema <input type="checkbox"/> Lower Extremity Pain	<input type="checkbox"/> Swelling <input type="checkbox"/> Tenderness
	<input type="checkbox"/> Digoxin	<input type="checkbox"/> Arrhythmia (A-Fib/A-Flutter/Abberancy) <input type="checkbox"/> Concomitant Use of Interacting Drug <input type="checkbox"/> CHF	<input type="checkbox"/> Digoxin Toxicity <input type="checkbox"/> Anorexia <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Headache
	<input type="checkbox"/> Magnesium	<input type="checkbox"/> Abnormal Weight Loss <input type="checkbox"/> Arrhythmia(s) <input type="checkbox"/> Chronic Alcoholism <input type="checkbox"/> Coma <input type="checkbox"/> Convulsion <input type="checkbox"/> Diabetic Acidosis <input type="checkbox"/> Diuretic Therapy	<input type="checkbox"/> Drowsiness <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Fatigue/Malaise <input type="checkbox"/> Hypocalcemia <input type="checkbox"/> Hypokalemia <input type="checkbox"/> Long-term Medication(s) <input type="checkbox"/> Muscular Paralysis
	<input type="checkbox"/> PT-INR <input type="checkbox"/> PTT	<input type="checkbox"/> Acute MI <input type="checkbox"/> Acute Pancreatitis <input type="checkbox"/> A-Fib/A-Flutter <input type="checkbox"/> Anemia	<input type="checkbox"/> Epistaxis <input type="checkbox"/> GI Bleeding <input type="checkbox"/> Hematuria <input type="checkbox"/> Hemorrhage
			<input type="checkbox"/> Long-term Antibiotics <input type="checkbox"/> Poisoning by Anticoagulant <input type="checkbox"/> Unstable Angina <input type="checkbox"/> Vitamin K Deficiency



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PAGE 1 OF 4 Form #ER 16005 Revised 06/01/06

PRINTED BY: BT8139 DATE 9/12/2006

BD624700398 MONROE, JAMES
 DOB: 09/08/67 Age: 38Y MR #: 709779
 Admit Date/Time: 09/04/06 2151P
 915 FALERO, WALLACE G



Baptist Nursing Chart

HEALTH Long Form

Page 3


Patient Name:

IV Push is medications given in < 16 minutes							MEDICATIONS		(Put medications in the same syringe on one line)				
Time	IV Push	Route					Medication	Dose	Site	Initials	Response to Medication		
		IM	SC	PO	Other	Repeat Med					Pain Scale	Other	Initials
22:12	✓	○	○	○	○	○	Morphine	4mg	#1	AS	2200	↓ pain	AS
22:15	✓	○	○	○	○	○	Zofran	4mg	#1	AS			
	○	○	○	○	○	○							
	○	○	○	○	○	○							
	○	○	○	○	○	○							
	○	○	○	○	○	○							
	○	○	○	○	○	○							
	○	○	○	○	○	○							
<input type="checkbox"/> TD Adult <input type="checkbox"/> DT Pedi <input type="checkbox"/> Tetanus Toxoid <input type="checkbox"/> Rabies <input type="checkbox"/> Rabies IG <input type="checkbox"/> Other <input type="checkbox"/> VAR Completed													
Thrombolytics: <input type="checkbox"/> Cardiac <input type="checkbox"/> Stroke <input type="checkbox"/> Vasopressors <input type="checkbox"/> Intraosseous Infusion <input type="checkbox"/> No response to med required													
PARENTERAL THERAPY - IV FLUIDS													
Site	Per Hr IV	KVO	Lock	Start TIME	Stop TIME	Hydration	Medication	Solution/Additive	Medication	Rate / Bolus	Repeat Med	Initials	
1	Site	○	○	○	22:18	22:45	○	✓	Anxet 2grms	200ml/hr	○	AS	
Time	Gauge	18					○	○			○		
	Attempts x	1					○	○			○		
							○	○			○		
2	Per Hr IV	○	○	○			○	○			○		
Time	Site						○	○			○		
	Gauge	x					○	○			○		
							○	○			○		
3	Per Hr IV	○	○	○			○	○			○		
Time	Site						○	○			○		
	Gauge	x					○	○			○		
							○	○			○		
INTAKE		Amount		OUTPUT		Amount		Response to IV therapy					
Oral		300		Urine		400		Tolerated well, no adverse reaction noted					
IV		100		Gastric									
Other				Other									
TOTAL		400		TOTAL		400		Blood Transfusion					
								<input type="checkbox"/> Routine <input type="checkbox"/> Emergent		IV Site at disposition			
								Total # of units		<input type="checkbox"/> No redness <input type="checkbox"/> No swelling <input type="checkbox"/> catheter intact			
Vital Signs				Continuous NIBP (strips attached)				Titrated Medications <input type="checkbox"/> See flow sheet					
Time	Temp	Pulse	Resp	B/P	Pulse Ox	Glucose Checks	Pain Scale	Time	Med #1	Med #2	Med #3	Initials	

PRINTED BY: b18139

DATE: 9/12/2006

Form ER 18002 Rev. 03/01/06

Airway and C-spine <input checked="" type="radio"/> WNL <input type="radio"/> Abnormal		<input type="radio"/> Clear <input type="radio"/> Obstructed <input type="radio"/> Intubated size _____ cm @ lip _____ <input type="radio"/> C-spine secured by ED staff		 B0624700388 MONROE, JAMES DOB: 09/08/67 Age: 38Y MR #: 709779 Admit Date/Time: 09/04/06 2151P 915 FALERO, WALLACE G	
Breath Sounds <input checked="" type="radio"/> WNL / Clear <input type="radio"/> Abnormal <i>decreased R</i>		<input type="radio"/> Rales <input type="radio"/> Rhonchi <input type="radio"/> Wheezes <input type="radio"/> Diminished <input type="radio"/> Absent	<input type="radio"/> R <input type="radio"/> L	<input type="radio"/> O <input type="radio"/> O <input type="radio"/> O <input type="radio"/> O <input type="radio"/> O	<input type="radio"/> O <input type="radio"/> O <input type="radio"/> O <input type="radio"/> O <input type="radio"/> O
Respiratory <input checked="" type="radio"/> WNL <input type="radio"/> Abnormal		<input type="radio"/> Labored <input type="radio"/> Apneic <input type="radio"/> Expiratory Grunting <input type="radio"/> Rapid <input type="radio"/> Retractions <input type="radio"/> Cough - Productive <input type="radio"/> Shallow <input type="radio"/> Stridor <input type="radio"/> Cough - Non-productive <input type="radio"/> Nasal Flaring <input type="radio"/> Tracheal deviation <input type="radio"/> Sputum: color _____			<input type="radio"/> Home Oxygen _____ L/min
Cardiovascular <input checked="" type="radio"/> WNL <input type="radio"/> Abnormal		<input type="radio"/> Tachycardic/weak <input type="radio"/> Chest Pain/Tightness <input type="radio"/> Irregular <input type="radio"/> Diaphoresis <input type="radio"/> Dizziness <input type="radio"/> Cyanosis <input type="radio"/> Arrhythmia <input type="radio"/> Edema <input type="radio"/> Pulses X 4			Notes: Monitor Rhythm <input type="radio"/> See Strips <input type="radio"/> ICD
Neurological <input checked="" type="radio"/> WNL <input type="radio"/> Not Assessed <input type="radio"/> Playful <input type="radio"/> Interactive with environment		<input type="radio"/> LOC <input type="radio"/> Combative <input type="radio"/> Lethargic <input type="radio"/> Headache <input type="radio"/> Syncope <input type="radio"/> Tremors <input type="radio"/> Disoriented <input type="radio"/> Seizures <input type="radio"/> Vertigo/Dizzy <input type="radio"/> Speech difficulty / slurred <input type="radio"/> Confusion <input type="radio"/> Unresponsive <input type="radio"/> Responds to Voice only <input type="radio"/> Responds to Pain only <input type="radio"/> Follows commands <input type="radio"/> Change in mental status <input type="radio"/> Moves all extremities			Notes: <input type="radio"/> Seizure precautions <input type="radio"/> Neuro vital signs (see NN) <input type="radio"/> Glasgow Coma Scale _____ <input type="radio"/> CVA Protocol (NIH Stroke Scale)
GI <input checked="" type="radio"/> WNL <input type="radio"/> Not Assessed		<input type="radio"/> N / V / D <input type="radio"/> Cramping <input type="radio"/> Constipation <input type="radio"/> Rigid Abd <input type="radio"/> vomiting x _____ <input type="radio"/> Pain <input type="radio"/> Distention <input type="radio"/> Tender Abd <input type="radio"/> BS + - <input type="radio"/> Bleeding <input type="radio"/> Weight Loss / Gain <input type="radio"/> Last BM _____			<input type="radio"/> Nutritional risk Yes No <input type="radio"/> Dentures Upper Lower <input type="radio"/> Meal Given
GU / GYN <input type="radio"/> WNL <input checked="" type="radio"/> Not Assessed		<input type="radio"/> Pregnant <input type="radio"/> Pain <input type="radio"/> Freq/urgency <input type="radio"/> Amenorrhea <input type="radio"/> G P A <input type="radio"/> Distention <input type="radio"/> Incontinent <input type="radio"/> Dysmenorrhea <input type="radio"/> EDC _____ <input type="radio"/> Hematuria <input type="radio"/> Flank pain L R <input type="radio"/> Vaginal Bleeding <input type="radio"/> FHTs _____ <input type="radio"/> Burning <input type="radio"/> Blood at Meatus <input type="radio"/> Discharge			Notes: <input type="radio"/> Ostomy _____ <input type="radio"/> Foley size _____ Urine description:
Musculo-skeletal <input type="radio"/> WNL <input type="radio"/> Not Assessed		<input type="radio"/> Pain <input type="radio"/> Unable to Assess Gait <input type="radio"/> Splinting <input type="radio"/> Swelling <input type="radio"/> Unsteady gait <input type="radio"/> Weakness <input type="radio"/> Deformity <input type="radio"/> Assist Device <input type="radio"/> History of falls			Notes: R L Handed Gait Device: Cane Walker Crutches W/C Prosthesis
Integumentary <input type="radio"/> Intact <i>See NN</i> <input type="radio"/> Not Assessed		<input type="radio"/> Bruises <input checked="" type="radio"/> Wound <input type="radio"/> Pale <input type="radio"/> Cyanotic <input type="radio"/> Jaundice <input type="radio"/> Rash <input checked="" type="radio"/> Laceration <input type="radio"/> Fistula: Location _____ <input type="radio"/> Abrasions <input type="radio"/> Lesions <input type="radio"/> Bruit + - <input type="radio"/> Thrill + -			Notes: <input type="radio"/> Exposure to Chemicals <input type="radio"/> Burns
EENT: <input type="radio"/> WNL <input checked="" type="radio"/> Not Assessed		<input type="radio"/> Eye R L Both Pupil size R _____ mm L _____ mm Hearing Aid: R L B <input type="radio"/> Ear R L Both <input type="radio"/> Drainage <input type="radio"/> Itching <input type="radio"/> Pain <input type="radio"/> Nose <input type="radio"/> Throat <input type="radio"/> Dental <input type="radio"/> Congestion <input type="radio"/> Redness			<input type="radio"/> Visual Acuity R 20/____ L 20/____ B 20/____ Glasses Contacts
Psychiatric: <input checked="" type="radio"/> WNL <input type="radio"/> Not Assessed		<input type="radio"/> Memory changes <input type="radio"/> Delusions <input type="radio"/> Calm <input type="radio"/> Suicidal ideations <input type="radio"/> Depression <input type="radio"/> Insomnia <input type="radio"/> Hostile <input type="radio"/> Homicidal ideations <input type="radio"/> Anxiety <input type="radio"/> Hallucinations <input type="radio"/> Agitated <input type="radio"/> Plan? Yes No			Notes: <input type="radio"/> Environment secured <input type="radio"/> Restraints Present
Suspected: <input checked="" type="radio"/> None <input type="radio"/> Child/Elder Abuse <input type="radio"/> Sexual Assault <input type="radio"/> Domestic Violence <input type="radio"/> Victim of Violent Crime		Communication Deficit: <input checked="" type="radio"/> No deficit <input type="radio"/> Language barrier <input type="radio"/> Hearing Impaired <input type="radio"/> Uses Sign Language <input type="radio"/> Visually Impaired <input type="radio"/> Altered Mental Status <input type="radio"/> Translator _____ Dominant Language: _____		Barriers to learning: <input checked="" type="radio"/> None <input type="radio"/> Physical limits _____ <input type="radio"/> Emotional _____ <input type="radio"/> Cultural _____ <input type="radio"/> Religious/Spiritual _____ <input type="radio"/> Suspected low literacy skills <input type="radio"/> Developmental disability Safety measures addressed <input checked="" type="radio"/> Side rails Up <input checked="" type="radio"/> ID Bracelet On <input type="radio"/> Risk of falls <input type="radio"/> Falls Bracelet	
Referrals/Reporting: <input type="radio"/> Social Service <input type="radio"/> Behavioral Health <input type="radio"/> Police / Security <input type="radio"/> CPS / APS / DHHR <input type="radio"/> Animal Bite <input type="radio"/> Poison Control <input type="radio"/> SART / SANE		Developmental Milestones <input checked="" type="radio"/> Achieved 130 <input type="radio"/> Delayed		Support System: <input type="radio"/> Lives Alone <input type="radio"/> Family/Significant Other <input type="radio"/> Minor w / Parent <input type="radio"/> Minor w/o Parent <input type="radio"/> Nursing Home <input type="radio"/> Assisted Living Home <input checked="" type="radio"/> Other Prison Marital Status: S M W D	
PRINTED: _____		Nurse Signature (Nurse completing assessment) ID # Time <i>A. Johnson RN</i> #20319 2150		DATE: _____	

O ER

O OP

06624700398 MONROE, JAMES
 DOB: 09/08/67 Age: 38Y MR #: 709779
 Admit Date/Time: 09/04/06 2151P
 915 FALERO, WALLACE G



Baptist Nursing Chart Long Form

Page 1

Patient Name: _____

Arrival Time: 2142

Family Doctor: _____

Triage Time: 2142

Date: 09/04 Source: ☒ Patient ☐ Other: _____ Birthdate: 9-8-67 Age: 38 ☐ Pediatric (>29 days - 12 years)
 Sex: ☒ M ☐ F LMP: N/A Weight _____ kg (Actual) Height 5'9 Immunization status: _____ Last Tetanus: UTD
 Allergies: ☒ NKA ☐ Latex Tetrals Allergy Reaction: _____

CHIEF COMPLAINT/Reason for Visit:

- ☐ Return visit Same Day
☐ Return visit within 72 hours
☐ Workers Comp

Stab wound to
 the Back

MODE / METHOD OF ACCESS

Arrival Mode: ☒ Automobile/Other ☐ Ambulance / Air ☐ Law enforcement ☐ Auto Assist
 Entered by: ☒ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Carried ☐ Other
 Patient Admitted from: ☐ Home ☐ Physician Office ☐ Nursing Home ☐ Hospital ☒ Other Prison
 Treatment Prior to Arrival: ☐ None ☐ Ice ☒ Dressing(s) ☐ Splint(s) ☐ C-collar/Backboard
☐ O2 Therapy ☐ IV ☐ Airway ☐ Medications ☐ Intubation ☐ CPR ☐ Monitor ☐ Glucose ☐ ACLS Protocol ☐ Decon

VITAL SIGNS TAKEN: ☐ SITTING ☐ LYING ☐ STANDING

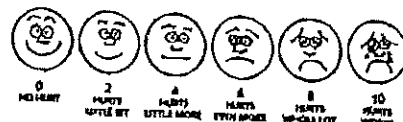
Time	Temp	Route	Pulse	Resp	B/P	Pulse Ox	Time	Orthostatic Vital Signs
<u>2145</u>		<u>oral</u>	<u>90</u>	<u>20</u>	<u>100/88</u>	<u>100%</u>		

PAIN SCALE

Numeric Scale 0=No Pain 10=Worst Pain Imaginable

☒ Pain Intensity Rate: 10 @ rest: _____

☐ Face Scale: (Faces Scale/Hung & Baker) / FLACC



Onset of pain: 1 hour ago

Location of pain: Upper Back

Quality: Sharp

Trauma Assessment ☐ Yes ☒ No

☐ Assault ☐ MVC Speed _____

☐ Stab Impact: Rear / Front / T-Bone

☐ GSW ☐ Driver ☐ Passenger

☐ Fire ☐ Front ☐ Rear

☐ Fall ☐ Airbag ☐ Restrained

☐ Motorcycle ☐ Bicycle

Helmet ☐ Yes ☐ No

☐ Other

Level of consciousness: ☒ A&O x3 ☐ disoriented to: person / place / time / situation
☐ dementia ☐ decreased LOC ☐ unconscious/comatose

Skin: ☒ Warm & Dry ☐ Hot ☐ Cool ☐ Cold ☐ Clammy ☐ Diaphoretic ☐ Pale

Safe in home: ☐ Yes ☐ No Intervention: Unable to assess (prison)

ADVANCE DIRECTIVES ☐ DNR ☐ LIVING WILL ☒ NONE ☐ Information Given

Past Medical History: ☐ Denies ☐ Unable to Assess

Exposure to: ☐ HIV ☐ Aids ☐ SARS ☐ STD Symptoms: _____

Vaccinations: ☐ Pneumonia ☐ Influenza ☐ Information Provided

Tobacco 12 Pack/day Alcohol denies Cigarettes/day Substance Abuse denies Cessation Advised

Neuro: CVA TIA Migraines Seizures

EENT: Cataract Glaucoma HOH Blind

Cardiac: MI CHF CABG HTN Pacer Dysrhythmia

Pulmonary: Asthma Bronchitis COPD Pneumonia

GI: Ulcers GI Bleed Constipation Diverticulitis

GU: UTI Kidney Stone Prostate Dialysis AV Shunt

Shoulder surgery

GYN: Pregnant now Ectopic

Ortho: Osteo Arthritis Back pain

Endo: Thyroid Diabetes

Cancer: _____

Psychiatric: Depression Alzheimer

Autism Parkinson's Bi-polar

Schizophrenia Prior Psych Admt

Hostile on admission

CURRENT MEDICATION(S)

Meds Disposition: ☐ Patient ☐ Family ☐ Other

☒ None ☐ See Medication List (attached)

☐ Narcotics Drug: _____ Count: _____

Nurse 1

Nurse 2

TRIAGE INTERVENTION(s): ☐ Ice/Elevation ☐ Dressing/Splint ☐ Glucose _____ ☐ EKG ☐ C-Collar ☐ Respiratory Precautions

Triage Category: _____

Triage disposition time: 2142 ☐ Waiting Room Time

Triage Nurse Signature: _____ ID # _____

Time: 9 ER Bed 628 ☐ FT Bed ☐ Hallway Bed



PRINTED BY: b18139

DATE: 9/12/2006

C. J. J. RN #20379

Form ER 16002 Rev. 06/13/06



Baptist

HEALTH

Page 1

Patient Name:

[illegible]

PRINTED BY: 518139

DATE 9/12/2006

Form ER 16002 Rev. 01/25/06



Sep. 12. 2006 ■ 3:02PM

06214700398 MONROE, JAMES
DOB: 09/08/67 Age: 38Y MR #: 709779
Admit Date/Time: 09/04/06 2151P
915 FALERO, WALLACE G

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23b

Baptist Health
EMERGENCY PHYSICIAN RECORD
Laceration Procedure / Conscious Sedation Notes

Wound Description #1Wound: BackSize: 4 -cm

Distal NVT:

sensation intact vascular intact tendon intact

Depth / shape / contamination:

superficial linear irregular flap
subcut nail avulsed stellate galea
muscle contused tissue traumatic laceration
clean traumatic avulsion vermilion border
contaminated minimally / moderately / *heavily
with dirt gravel grease ink

ANESTHESIA

local LET / tetracaine / adrenaline / cocaine digital block _____ mL
lidoc 2% epi / bicarb marcaine 0.25% 0.5%
PSA conscious sedation

WOUND PREP AND REPAIR

Hibiclens / Betadine foreign material removed
betadine to skin partially completely
wound cleanser minimal / mod. / *extensive
irrigated / washed w/ saline debrided
moderate / *extensive minimal / *mod. / *extensive
wound explored undermined
pressure dressing minimal / mod. / *extensive
sharp excision

Wound closed with: wound adhesive / steri-strips

SKIN

6 -0 nylon / prolene / vicryl / staples / fast gut
interrupted running simple mattress (h/v)

***SUBCUTICULAR / SUBCUTANEOUS / MUCOSA**

3 4 -0 vicryl / silk / chromic gut
interrupted running simple mattress (h/v)

***FASCIA / MUSCLE / TENDON**

_____ -0 vicryl / galea
interrupted running simple mattress (h/v)

NAIL / NAIL MATRIX

nail excised nail reattached # _____ -0 vicryl /
nail bed reconstruction rongueured bone fingertip amputation

OTHER retention suture placed extensive undermining stents
wound revision ligated bleeders removal hematoma sharp excision
penrose drain rongueured bone

☒ Simple Repair ☒ Intermittent Repair ☐ Complex Repair

Wound Description #2

Wound: _____

Size: _____ -cm

Distal NVT:

sensation intact vascular intact tendon intact

Depth / shape / contamination:

superficial linear irregular flap
subcut nail avulsed stellate galea
muscle contused tissue traumatic laceration
clean traumatic avulsion vermilion border
contaminated minimally / moderately / *heavily
with dirt gravel grease ink

ANESTHESIA

local LET / tetracaine / adrenaline / cocaine digital block _____ mL
lidoc 1% 2% epi / bicarb marcaine 0.25% 0.5%
PSA conscious sedation

WOUND PREP AND REPAIR

Hibiclens / Betadine foreign material removed
betadine to skin partially completely
wound cleanser minimal / mod. / *extensive
irrigated / washed w/ saline debrided
moderate / *extensive minimal / *mod. / *extensive
wound explored undermined
pressure dressing minimal / mod. / *extensive
sharp excision

Wound closed with: wound adhesive / steri-strips

SKIN

_____ -0 nylon / prolene / vicryl / staples / fast gut
interrupted running simple mattress (h/v)

***SUBCUTICULAR / SUBCUTANEOUS / MUCOSA**

_____ -0 vicryl / silk / chromic gut
interrupted running simple mattress (h/v)

***FASCIA / MUSCLE / TENDON**

_____ -0 vicryl / galea
interrupted running simple mattress (h/v)

NAIL / NAIL MATRIX

nail excised nail reattached # _____ -0 vicryl /
nail bed reconstruction rongueured bone fingertip amputation

OTHER retention suture placed extensive undermining stents
wound revision ligated bleeders removal hematoma sharp excision
penrose drain rongueured bone

☐ Simple Repair ☐ Intermittent Repair ☐ Complex Repair

*may indicate intermediate repair. *may indicate intermediate or complex repair.
Repair of muscles or tendons in complex wounds is reported with appropriate separate repair codes.

MD / DO _____
Resident _____
Attending _____
Physician.

PRINTED BY _____ DATE 9/12/2006

CONSCIOUS SEDATION PROCEDURE NOTE

Time: _____

Indications- _____ laceration _____ shoulder dislocation _____

_____ see nurses record for monitoring / vital signs
_____ last meal _____ time: _____

Preparation- _____ procedure explained _____

_____ to patient _____ to parent / guardian

_____ consent signed (if applicable) _____

_____ pulse oximeter _____

_____ oxygen _____ (if applicable)

_____ IV access (if applicable) _____

_____ suction (if applicable) _____

_____ cardiac monitor (if applicable) _____

_____ constant attendance (if applicable) _____

Physical Exam-

AIRWAY _____ difficult facial / neck anatomy _____

_____ oral anatomy _____

CVS / RESP _____ respiratory distress _____

_____ normal heart sounds _____ wheezing / rales _____

_____ normal breath sounds _____

NEURO _____ lethargic _____

_____ alert _____ anxious _____

_____ NAD _____ distress mild / moderate / severe _____

_____ responsive _____ confused / disoriented _____

_____ unresponsive _____

Sedation- PO: _____ versed _____

_____ fentanyl lollipop _____

_____ ketamine _____

RECTAL: _____ versed _____

_____ chloral hydrate _____

PARENTERAL: _____ versed _____

_____ fentanyl _____

_____ ketamine _____

_____ brevilcal _____

ASA Classification

P1. Normal healthy patient

P2. Patient with a mild systemic disease

P3. Patient with severe systemic disease

P4. Patient with severe systemic disease that is a constant threat to life

P5. Moribund patient who is not expected to survive w/o the operation

Response during procedure-

light moderate heavy sedation

vital signs stable _____

oxygenation stable _____

maintained airway well during procedure _____

handled secretions adequately _____

Complications during / after procedure-

none _____

vomiting _____

apnea _____

airway compromise _____

O2 desaturation _____

hypotension _____

new neurologic problems _____

agitation _____

Reversal-

none _____

narcan _____

romazicon _____

Mental Status after procedure-

Appearance _____

Alert Lethargic Anxious _____

Distress _____

NAD mild moderate severe _____

Response To Verbal Stimuli _____

confusion / disorientation _____

unresponsive _____

patient returned to pre-procedure baseline

alert prior to discharge _____

x _____ MD / DO x _____ MD / DO

Resident

Attending

☐ If review, Patient interviewed, Medical Decision Making, and Examined by Physician.

DATE 9/12/2006

Laceration Add-on - 23b

PRINTED BY: b18139

B0624700388 MONROE, JAMES
DOB: 09/08/87 Age: 38Y MR #709779
Admit Date/Time: 09/04/06 2151P
915 FALERO, WALLACE G

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07

Baptist Health
EMERGENCY PHYSICIAN RECORD
Trunk Injury (5)

DATE: TIME: 2:40 ROOM: 110 EMS Arrival
HISTORIAN: patient spouse paramedics
HX / EXAM UNOBTAINABLE 2° TO:

HPI

chief complaint / location of injury:
chest back abdomen neck

context: fall blow incision stab burn GSW

severity of pain: mild moderate severe

occurred:
just PTA
today 2:40
yesterday
days PTA

where:
home school
neighbor's city park
work street

blow to head?
no yes
if yes, LOC? no dazed yes

location of pain / injury:
head face neck
chest abdomen

if LOC remembers:
injury coming to hospital
back upper mid lower
radiating to R/L thigh / leg

PAST HX negative HTN DM CAD

PSK - Shoulder L

Meds: none / see nurse's note

Allergies: NKDA see nurse's note

SOCIAL HX recent ETOH smoker drug abuse

FAMILY HX DM HTN CAD

HX / EXAM UNOBTAINABLE 2° TO:

ROS ☐ all systems neg except as mtd

NEURO / MS
loss feeling / power arms / legs
headache / neck pain

EYES
double vision

ENT
hearing loss

RESPIRATORY
trouble breathing

CVS
chest pain

GI
nausea / vomiting

GU
loss of bladder function

SKIN
skin laceration

CONST
recent fever / illness

☐ Nursing Assessment Reviewed ☐ Vitals Reviewed ☒ Tetanus immun. UTD

PHYSICAL EXAM

General Appearance c-collar (PTA / in ED) / backboard
no acute distress mild / moderate / severe distress
alert anxious / lethargic

HEAD

no evidence of trauma
see diagram
Barth's sign / Raccoon Eyes

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NECK
non-tender
painless ROM
trachea midline

EYES
PERIL
EOMI

ENT
nmil external
no dental injury

RESPIRATORY
chest non-tender
breath sounds nmil

CVS
heart sounds nmil
reg. rate, rhythm
no JVD
no murmur
no gallop
no friction rub

see diagram
vertebral point-tenderness
muscle spasm / decreased ROM
pain on movement of neck

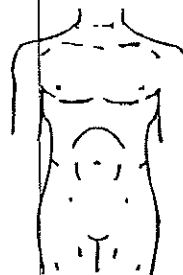
unequal pupils R- mm L- mm
EOM entrapment / palsy
subconjunctival hemorrhage
pale conjunctivae

hemotympanum

see diagram
decreased breath sounds
wheezing / rales
splinting / paradoxical movements

irregularly irregular rhythm
ectopic beats (occasional / frequent)
tachycardia / bradycardia
JVD present
murmur grade /b sys/dias
cresc / cresc-decresc / decresc
gallop (S3 / S4)

decreased pulse(s)



see
reverse
for back
diagram

T=Tenderness
PT=Point Tenderness
S=Swelling
E=Ecchymosis
Lac=Laceration
A=Abrasion
B=Burn
(B without m=mild
mod=moderate s=severe)
Ttr=Tenderness on
palpation (severe)

GASTROINTESTINAL
non-tender
no organomegaly

see diagram
rebound / tenderness
nlsg / organomegaly

GENITAL EXAM
nmil genital exam
nmil vaginal exam

perineal hematoma
blood at urethral meatus

RECTAL EXAM
nmil rectal exam
heme neg. stool

decreased rectal tone

NEURO / PSYCH
oriented x3
mood & affect
CN's nmil
as tested
sensation & motor nmil

confused / disoriented
EOM palsy / anisocoria
facial asymmetry
sensory / motor deficit
poststeady / ataxic gait



SKIN
intact
warm, dry

see diagram
crepitus / diaphoresis

DATE 09/04/06 RN/PA/NP sign after recording history, physician initial after reviewing with patient and confirming or revising all elements.

BACK
 no CVA
 tenderness
 no vertebral
 tenderness

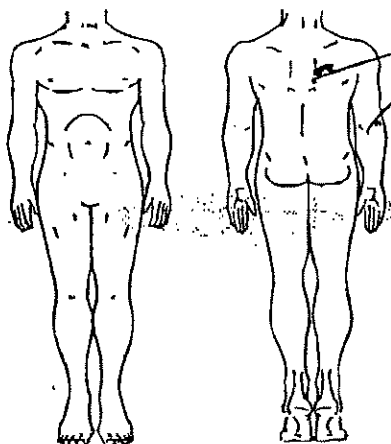
see diagram Sub Wound
 vertebral point-tenderness
 CVA tenderness
 muscle spasm
 limited ROM

HIPS / PELVIS
 pelvis stable
 hips non-tender

see diagram
 bony point-tenderness
 painful / unable to bear weight

EXTREMITIES
 no evidence
 of trauma
 nml ROM
 no pedal edema

see diagram R Elbow
 bony point-tenderness
 painful / unable to bear weight
 joint Exam
 limited ROM / ligaments laxity / joint effusion



Mark
 back and
 extremity
 findings
 on these
 diagrams

PROCEDURES:

CHEST TUBE INSERTION (French) Betadine prep
 anesthesia- mL local lidocaine / marcaine /
 position- mid / outer / post axillary line interspace
 sutured in place position confirmed on CXR
 return- air / blood connected to suction

repeat CXR 0215
No pneumothorax

LABS, EKG & XRAYs

CBC normal except WBC Hgb Hct Platelets segs. bands lymphs monos eos	Chemistries normal except BUN Creat Gluc Alk Phos ALT AST Na K Cl	CO2 Ca Bilirubin Magnesium BNP D-Dimer	UA normal except WBC RBC bacteria dip
---	--	--	---

EKG MONITOR STRIP NSR Rate
 normal abnormal

EKG NML ☐ Interp. by me ☐ Reviewed by me Rate
 NSR nml intervals nml axis nml QRS nml ST/T

not / changed from:

XRAYs ☒ Interp. by me ☒ Reviewed by me ☐ Discd w/ radiologist

C-Spine **D-Spine** **L5-Spine**
 nml / NAD reversal / straightening of cerv. lordosis
 no fracture DJD / spondylosis / spurring
 nml alignment
 soft tissues nml

CXR
 nml / NAD rib fracture
 no infiltrates infiltrate / atelectasis
 nml heart size
 nml mediastinum

OTHER ☐ See separate report

CT SCAN chest abd pelvis
 normal

PROGRESS:

Re-evaluation time	unchanged	improved	re-examined
Re-evaluation time	unchanged	improved	re-examined
Re-evaluation time	unchanged	improved	re-examined

use template #235 for Laceration Repair

TREATMENT:

MEDICAL DECISION:

Fracture Care: Follow up with orthopedic within 48 hours

Rx given

Follow up with

Relinquished care to Dr. Time:

referred to / discussed with Dr.

will see patient in: office / ED / hospital in days

Counseled patient / family regarding: **CRIT CARE** 30-74 min

lab results abnormal need for follow-up 75-104 min

☒ Rx given ☐ Admit orders written Additional history from:

Prior records ordered family caretaker paramedics

CLINICAL IMPRESSION:

Contusion Rib Fracture

chest abdomen back clinical dx shown on x-ray

Sprain / Strain displaced / comminuted

neck thoracic lumbar

Abrasion Laceration

Injury

Sub Wound of Back & Elbow

DISPOSITION: ☒ home ☐ admitted ☐ transferred

CONDITION: ☐ unchanged ☐ improved ☒ stable

☒ Resident ☐ MD / DO ☐ Attending

☒ Jlx review, Patient interviewed, Medical Decision Making, and Examined by Physician.

PRINTED BY: b18139

DATE 9/12/2006

Injury to Trunk - 07

No. 2588 P. 16/24

Sep. 12, 2006 3:03PM

MONROE, JAMES
 B0624700398
 DOB: 09/08/67 Age: 38Y MR #: 709779
 Admit Date/Time: 09/04/06 2151P
 915 FALERO, WALLACE G



ER PRESCRIPTION & DISCHARGE INSTRUCTIONS

Page 2 of 3

DISCHARGE INSTRUCTIONS - PATIENT COPY

Weight	Phone	Allergies	Location SOUTH
MEDICINES PRESCRIBED		If non, check this box: <input type="checkbox"/>	VOID IF NOT PRINTED WITH CRANBERRY BACKGROUND.

Name/Strength;	Number	Schedule / Duration	No Refills	Refills
1. <i>Kodex 500mg</i>	<i># 90</i>	<i>1 BID x 10 days</i>	<input checked="" type="checkbox"/>	
2. <i>Licet 7.64</i>	<i># 12</i>	<i>1 Q4 - 6 pm for pain</i>	<input checked="" type="checkbox"/>	
3. 	 	 	<input type="checkbox"/>	
4. 	 	 	<input type="checkbox"/>	
5. 	 	 	<input type="checkbox"/>	

INSTRUCTIONS SHEET(S) GIVEN

- | | | | | |
|--|------------------------------------|--|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Crotchets | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Threatened Ab | Return for signs of infection:
Increased Redness
Increased Swelling
Increased Drainage
Increased Heat |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Fever | <input type="checkbox"/> Otitis Media | <input type="checkbox"/> Vomiting / Diarrhea | |
| <input type="checkbox"/> Cast/ Splint Care | <input type="checkbox"/> Fracture | <input type="checkbox"/> Sprains / Bruises | <input type="checkbox"/> Wound Care | |
| | | <input type="checkbox"/> ST | <input type="checkbox"/> Other(s) | |

Additional Instructions:

1. EKG PMO 1st 2-3 days
2. EKG 2nd 7-10 days

Referred to:

- | | |
|--|--|
| <input type="checkbox"/> Dr. _____ | <input type="checkbox"/> Return to Emergency Dept in _____ hours / days for recheck. |
| Phone: _____ | <input type="checkbox"/> If no improvement or your condition worsens, call your private physician or return to the Emergency Department for a recheck. |
| <input type="checkbox"/> Call on next business day for follow-up appointment in _____ days / weeks | <input type="checkbox"/> Learning needs assessed <input type="checkbox"/> Instructions Modified |
| <input type="checkbox"/> Next available | <input type="checkbox"/> Education provided on new Medication |

I understand that the treatment I have received was rendered on an emergency basis and is not meant to replace complete care from a primary care provider or clinic. Furthermore, I may have been released before all of my medical problems were apparent, diagnosed, and/or treated. If my condition worsens, I have been instructed to call my primary care provider or return to this facility or the nearest emergency center. I understand that I should NOT drive or perform hazardous tasks if my medication or treatment causes drowsiness. I have read and understand the above, received a copy of this form and applicable instruction sheets, and I will arrange for follow-up care. If diagnostic tests indicate a need for modification in therapy, you will be notified at the phone number you provided.

[Signature] Patient ☒ Relative ☐ Other ☐ Time Released: *02:30*

INSTRUCTED BY: <i>[Signature]</i> RN	PHYSICIAN: <i>[Signature]</i>
---	----------------------------------

WORK/SCHOOL STATEMENT from the Emergency Department

PATIENT	DATE
<input type="checkbox"/> Patient was seen by Dr. _____ <input type="checkbox"/> No athletics / physical education: _____ days <input type="checkbox"/> May return to work/school without restrictions <input type="checkbox"/> Will require time off work / school. Estimated time: _____ days* <input type="checkbox"/> Must be reevaluated by family / occupational physician before returning to school / work.	
<input type="checkbox"/> May return to restricted duties for _____ days* Restrictions: _____ <input type="checkbox"/> _____ was here with relative/child. <input type="checkbox"/> Other _____	

Time off from school or work longer than three days should be approved by a Personal or Company/Occupational Medicine Physician, unless otherwise stated.



ER 160

PRINTED BY: B18139

DATE 9/12/2006

FORM # ER 16003 REV. 03/07/06

AdmPhys: Falero, Wallace G, MD

Admit date: 9/4/2006

Discharge date: 9/5/2006

HEMATOLOGY

Routine Hematology

COLLECTION DATE: 9/4/06
COLLECTION TIME: 10:02:00 PM

		REF RANGE	UNITS
WBC	10.5 H	[4.1-10.3]	X10 ³ /uL
RBC	4.88	[4.69-6.13]	X 10 ⁶ /uL
Hemoglobin	14.2	[13.0-17.5]	gm/dl
Hematocrit	41.0	[40.0-51.0]	%
MCV	84	[81-100]	FL
MCH	29	[27-31]	pg
MCHC	35	[32-35]	gm/dl
Platelet Count	279	[140-400]	X10 ³ /uL
RDW	13.5	[11.5-14.5]	%

Automated Differential

COLLECTION DATE: 9/4/06
COLLECTION TIME: 10:02:00 PM

		REF RANGE	UNITS
Neutro Auto	63	[40-75]	%
Lymph Auto	26	[20-53]	%
Mono Auto	9	[0-12]	%
Eos Auto	2	[0-8]	%
Basophil Auto	1	[0-2]	%
Neutro Abs	6.7 H	[1.4-6.5]	#
Lymph Abs	2.7	[1.0-4.8]	#
Mono Abs	0.9 H	[0.1-0.6]	#
Eos Abs	0.2	[0.0-0.7]	#
Basophil Abs	0.1	[0.0-0.2]	#

%%END

PRINTED BY: b18139

DATE 9/12/2006

NAME: MONROE, JAMES
MR#: 709779
DOB: 09/08/1967
AGE: 38 Y
SEX: M
BAPTIST SOUTH
2105 East South Boulevard
Montgomery, Alabama 36116

NAME: MONROE, JAMES
DOB: 09/08/1967
LOC: B-Emerge... RM/BD:
SEX: M AGE: 38 Y
METHOD: Stretcher PRIORITY: Stat

SPECIAL EQUIPMENT

EXAM: CT Chest w/ contrast

NAME: MONROE, JAMES
DOB: 09/08/1967
EXAM DATE/TIME: 09/04/2006 22:00
ENTRY DATE: 09/04/2006
ENTERED BY: Heard, Robert M
REASON/DIAGNOSIS: injury-cra i.v c...

PRIORITY: Stat

MR#: 709779

AGE: 38 Y

SEX: M

ORDERING MD: Alexander, D Gregory, MD

ATTENDING MD: Falero, Wallace G, MD

PREVIOUS EXAM: DX Chest Portable

DATE: 09/04/2006

BUN:

CREATININE:

WT:

SPECIAL EQUIPMENT AND INDICATION:

OTHER EXAMS ORDERED TODAY:
DX Chest Portable

COMMENTS:

NM AUTHORIZED USER:



CT-06-0034480

NAME: MONROE, JAMES

MR#: 709779

DOB: 09/08/1967

ORDERING MD: Alexander, D Gregory, MD

REASON/DIAGNOSIS: injury-cra i.v contrast only

EXAM DATE/TIME: 09/04/2006 22:00

PRIORITY: Stat

EXAM: CT Chest w/ contrast

COMMENTS:

LOC: B-Emergency Dep RM/BD:

AGE: 38 Y

SEX: M



28-06-0034480 09/08/1967

CRA
SW

PRINTED BY: b18139

DATE 9/12/2006

Case 2:06-cv-00928-MEF-TFM Document 21-2 Filed 01/16/2007 Page 46 of 53
NAME: MONROE, JAMES
MR# 709779
DATE: 09/04/2006 AGE: 38 Y
DOB: 09/08/1967 SEX: M
BAPTIST SOUTH
2105 East South Boulevard
Montgomery, Alabama 36116

NAME: MONROE, JAMES
DOB: 09/08/1967
LOC: B-Emerge... RM/ED:
SEX: M AGE: 38 Y
METHOD: Stretcher PRIORITY: Stat

SPECIAL EQUIPMENT

EXAM: DX Chest Portable

NAME: MONROE, JAMES
DOB: 09/08/1967
EXAM DATE/TIME: 09/04/2006 22:00
ENTRY DATE: 09/04/2006
ENTERED BY: Roberson, Latasha N, PCT
REASON/DIAGNOSIS: injury-cra

PRIORITY: Stat
MR# 709779
AGE: 38 Y
SEX: M
ORDERING MD: Alexander, D Gregory, MD
ATTENDING MD: Palero, Wallace G, MD
PREVIOUS EXAM:

BUN:
CREATININE:
WT:

SPECIAL EQUIPMENT AND INDICATION:

OTHER EXAMS ORDERED TODAY:

COMMENTS:

CPA

MR AUTHORIZED USER:

DX-06-0098916

NAME: MONROE, JAMES
MR# 709779
DOB: 09/08/1967
ORDERING MD: Alexander, D Gregory, MD
REASON/DIAGNOSIS: injury-cra
EXAM DATE/TIME: 09/04/2006 22:00
PRIORITY: Stat
EXAM: DX Chest Portable
COMMENTS:

LOC: B-Emergency Dep RM/ED:
AGE: 38 Y SEX: M

39-06-0098916 09/08/1967

mild scoliosis
0
SL

PRINTED BY: b18139 DATE: 9/12/2006

MR. B000709778 Acct. B0624700398
AdmPhys: Falero, Wallace G, MD
Admit date: 9/4/2006 Discharge date: 9/5/2006

RADIOLOGY

Procedure Name:	Accession	Procedure	Ordering Physician:
	Number:	Date/Time:	
CT Chest w/ contrast	CT-06-	9/4/2006	Alexander, D
	0034480	11:22:54 PM	Gregory, MD

Reason For Exam:
injury-cra i.v contrast only

FINDINGS
MONROE, JAMES

CT CHEST:

Stab injury. Axial contrast images are obtained to evaluate a stab injury. A marker was placed over the right posterior chest wall at the area of interest and this is subsequently shown to be at about the level of the aortic knob in the right paraspinal soft tissues posteriorly. The study shows the lungs to be normally expanded, but no evidence of infiltrate, fluid or pneumothorax. Mediastinal vessels enhance normally. No soft tissue mass could be seen at the injury site and there is no evidence of radiopaque foreign body.

IMPRESSION:
NEGATIVE EXAM.

ELECTRONICALLY SIGNED BY: Williams, Russell S

TECHNOLOGIST: RMH
TRANSCRIBED DATE AND TIME: 09/05/2006 06:54
TRANSCRIPTIONIST: ARH

Procedure Name:	Accession	Procedure	Ordering Physician:
	Number:	Date/Time:	
DX Chest Portable	DX-06-	9/4/2006	Alexander, D
	0098916	10:11:33 PM	Gregory, MD

Reason For Exam:
injury-cra

%%END

PRINTED BY: b18139 DATE 9/12/2006

RADIOLOGY

Procedure Name:	Accession Number:	Procedure Date/Time:	Ordering Physician:
DX Chest Portable	DX-06-0098916	9/4/2006 10:11:33 PM	Alexander, D Gregory, MD

FINDINGS
MONROE, JAMES

PORTABLE CHEST:

Injury.

There is a mild scoliosis, convex right. The lungs are well expanded and the exam is somewhat underpenetrated. Allowing for this, I see no evidence of infiltrate, mass or fluid. Heart and pulmonary vasculature are normal.

IMPRESSION: MILD SCOLIOSIS.

ELECTRONICALLY SIGNED BY: Williams, Russell S

TECHNOLOGIST: CJC
TRANSCRIBED DATE AND TIME: 09/05/2006 06:51
TRANSCRIPTIONIST: jrm

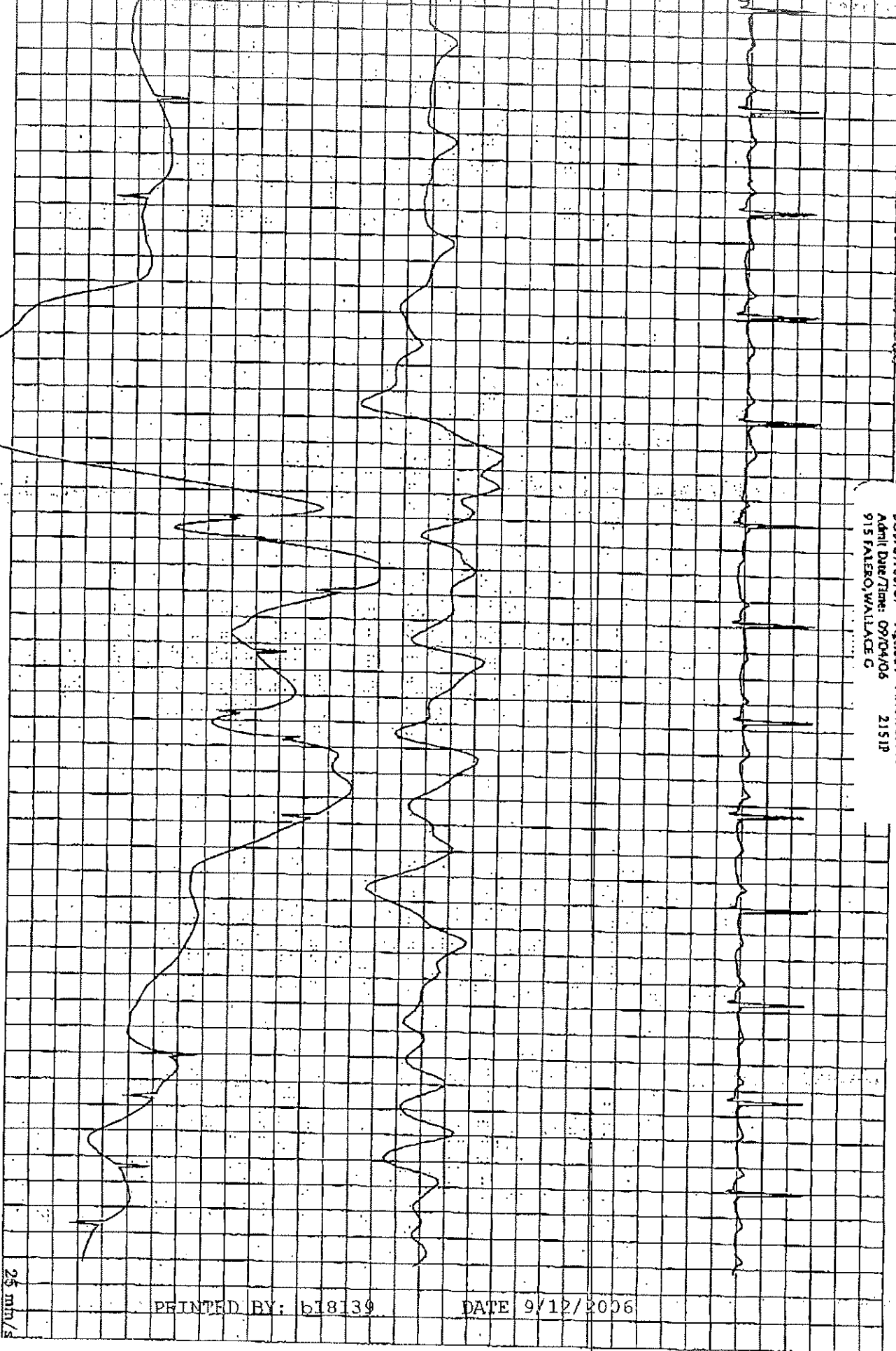
*8END

PRINTED BY: b18139 DATE 9/12/2006

999999999 9/5/2006 2:09:33 AM
HR 75 ST V1 1.2 mm
SPD2.99% #RATE 75 RR-11 23 MBP X / X (X)

DOB: 09/08/67 Age: 38Y MR 6/709779
Admit Date/Time: 09/04/06 2151P
915 FAIRCO, WALLACE C

ED/CASTA



PRINTED BY: b18139

DATE 9/12/2006

BO624700398

DOB: 09/08/67 App: JBY MR #: 709779

Admit Date/Time: 08/04/06 2151P

915 FALERO, WALLACE G

Date Printed: 5 Sep 2006

Time Printed: 02:24

Page: 1 of 1

[illegible]

OEMS Information Technologies

DATE 9/12/2006

No. 2588—P. 24/24

Sep. 12. 2006 3:05PM

PROCEDURES / TREATMENT CARE		MONROE, JAMES					
EYE	NOSE/EAR	DOB: 09/08/87	Age: 33Y MR #: 709779				
<input type="checkbox"/> Eye Exam - NO FB found <input type="checkbox"/> FB Eye Exam/Slit lamp <input type="checkbox"/> FB Eye Exam/No Slit lamp <input type="checkbox"/> Eye irrigation R L Both Amount _____	<input type="checkbox"/> Nasal Caotery <input type="checkbox"/> Nasal packing-anterior <input type="checkbox"/> Nasal packing-posterior <input type="checkbox"/> Nasal packing-balloon <input type="checkbox"/> Ear irrigation (ear wax) R L	B0624700398 Admit Date/Time: 09/04/08 2151P 915 FALERO, WALLACE G					
<input type="checkbox"/> Procedure "Time Out" by: _____							
CARDIOLOGY	GI / GU	RADIOLOGY	SPECIAL PROCEDURES				
<input checked="" type="checkbox"/> Cardiac monitor <input type="checkbox"/> EKG - by ED staff <input type="checkbox"/> Repeat EKG by ED staff <input checked="" type="checkbox"/> Pulse Ox-continuous <input type="checkbox"/> Central line <input type="checkbox"/> < 5yr <input type="checkbox"/> ≥ 5yr <input type="checkbox"/> External pacer <input type="checkbox"/> Temporary internal pacer <input type="checkbox"/> Cardioversion (electric) <input type="checkbox"/> Pericardiocentesis <input type="checkbox"/> Declot vascular device <input type="checkbox"/> PICC line <input type="checkbox"/> < 5yr <input type="checkbox"/> ≥ 5yr <input type="checkbox"/> Arterial Blood Gas <input type="checkbox"/> Blood / Needle exposure	<input type="checkbox"/> Straight/quick cath for UA <input type="checkbox"/> Foley catheter Size _____ <input type="checkbox"/> Bladder irrigation <input type="checkbox"/> Foley removed <input type="checkbox"/> Rectal exam <input type="checkbox"/> Anoscopy <input type="checkbox"/> Rectal disimpaction <input type="checkbox"/> Enema <input type="checkbox"/> Repeat x _____ <input type="checkbox"/> NG w/ suction _____ <input type="checkbox"/> NG w/ Lavage _____ <input type="checkbox"/> G-tube replace <input type="checkbox"/> Reposition <input type="checkbox"/> Pelvic Exam <input type="checkbox"/> Sexual Assault Exam <input type="checkbox"/> Incontinence Care	<input checked="" type="checkbox"/> X-Ray preparation <input checked="" type="checkbox"/> CT <input type="checkbox"/> US <input type="checkbox"/> MRI <input type="checkbox"/> IVP <input type="checkbox"/> IV contrast <input type="checkbox"/> Oral contrast <input type="checkbox"/> Monitor in radiology / CT LAB <input checked="" type="checkbox"/> Venipuncture (ED Staff) <input checked="" type="checkbox"/> Lab Test (any) <input type="checkbox"/> Specimen collection (not blood) <input type="checkbox"/> Point of care test <input type="checkbox"/> Urine Dip <input type="checkbox"/> Rapid Strip <input type="checkbox"/> Central line blood draw <input type="checkbox"/> Hemocult + - <input type="checkbox"/> Genital cultures	<input type="checkbox"/> Isolation (Medical) <input type="checkbox"/> Lumbar puncture <input type="checkbox"/> Epidural blood patch <input type="checkbox"/> Procedural sedation IV/IM <input type="checkbox"/> Paracentesis / Dx lavage <input type="checkbox"/> Hypothermia care <input type="checkbox"/> Hyperthermia care				
PULMONARY		BEHAVIORAL MANAGEMENT					
<input type="checkbox"/> Airway: Oral/Nasal <input type="checkbox"/> Oxygen Mask Cannula _____ Liters/min <input type="checkbox"/> Intubation Tube: _____ <input type="checkbox"/> PTA <input type="checkbox"/> ED <input type="checkbox"/> Anesthesia <input type="checkbox"/> Rapid sequence induction <input type="checkbox"/> Ventilation assist Bi-Pap C-Pap		<input type="checkbox"/> End-tidal CO2 + - <input type="checkbox"/> Thoracentesis (Needle) <input type="checkbox"/> Chest tube insertion Tube size: _____ R / L <input type="checkbox"/> Bilateral <input type="checkbox"/> Nebulizer(s) X _____					
<input type="checkbox"/> CPR <input type="checkbox"/> CODE Time: _____ Medical Pediatric Trauma <input type="checkbox"/> Code Sheet Completed Trauma team <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3							
DISPOSITION / OUTCOME							
PATIENT PROPERTY: <input type="checkbox"/> Sent home <input type="checkbox"/> Secured / hospital safe <input type="checkbox"/> Patient retains/accepts responsibility <input checked="" type="checkbox"/> Sent with patient <input type="checkbox"/> Dentures <input type="checkbox"/> Glasses <input type="checkbox"/> Hearing device <input type="checkbox"/> Clothing <input type="checkbox"/> Cane <input type="checkbox"/> Crutches <input type="checkbox"/> Walker <input type="checkbox"/> Valuables <input type="checkbox"/> Other: _____							
<input checked="" type="checkbox"/> Discharged Time 0720 <input type="checkbox"/> Nursing Home <input type="checkbox"/> AMA / Elopement <input type="checkbox"/> LBMSE / LBT		Admitted Time _____ Room _____ <input type="checkbox"/> Regular Room <input type="checkbox"/> Telemetry <input type="checkbox"/> ICU / CCU <input type="checkbox"/> Surgery <input type="checkbox"/> Cath Lab <input type="checkbox"/> Psychiatric <input type="checkbox"/> Observation					
<input type="checkbox"/> Transferred Time: _____ <input type="checkbox"/> Hospital <input type="checkbox"/> Psychiatric <input type="checkbox"/> Extended Stay (>4 hours)		<input type="checkbox"/> Expired Time: _____ <input type="checkbox"/> Coroner called <input type="checkbox"/> Released to Funeral Home <input type="checkbox"/> Organ donation addressed					
TEACHING / DISCHARGE CARE							
Smoking cessation advised <input checked="" type="checkbox"/> < 3 min <input type="checkbox"/> ≥ 3 min <input checked="" type="checkbox"/> Discharge instruction sheet provided <input checked="" type="checkbox"/> Verbal understanding of discharge / RX <input type="checkbox"/> Meds dispensed by physician <input type="checkbox"/> Extended patient education		CORE MEASURES: <input type="checkbox"/> AMI <input type="checkbox"/> Pneumonia <input type="checkbox"/> Heart Failure <input type="checkbox"/> Stroke Instruction(s) given to: <input checked="" type="checkbox"/> Patient <input type="checkbox"/> Parent / Family <input type="checkbox"/> Friend <input type="checkbox"/> Other _____					
<input type="checkbox"/> Work/School Excuse (see copy) <input type="checkbox"/> Workers Comp Papers Initiated (see copy) <input type="checkbox"/> ED Boarder Time: _____		Discharge Mode: <input type="checkbox"/> Ambulatory <input type="checkbox"/> Carried <input type="checkbox"/> Ambulance <input type="checkbox"/> Crutches <input checked="" type="checkbox"/> Wheelchair <input type="checkbox"/> Stretcher					
Accompanied by: <input type="checkbox"/> Self / Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Friend <input type="checkbox"/> Police <input type="checkbox"/> Family <input checked="" type="checkbox"/> Other 6/20/08/CA							
TRIAGE OUT VITAL SIGNS							
Time	Temp	Pulse	Resp	B/P	Pulse OX	Pain Scale	FHT
0724	—	TT	20	121/85	100%	5	
Condition: <input type="checkbox"/> improved <input type="checkbox"/> unchanged <input type="checkbox"/> _____							
Signature and Employee ID 06/20/08 RN				Triage Out Note: NAD noted. Patient stable for discharge.			
Admit Report called to: _____ Time: _____				Signature and Employee ID 06/20/08 RN 20519			
PRINTED BY: b18139				DATE 9/16/08			



DEPARTMENT OF CORRECTIONS

AUTHORIZATION FOR RELEASE OF INFORMATION

To: Baptist South From: SHCuElmorePatient: Monroe James Inmate ID No.: 167435 SCCAlias: _____ Social Security No.: 418 - 94 - 4089Date of Birth: 9/8/67 Date(s) of Service: 9-4-06

I hereby authorize the above named provider to release to Prison Health Services, Inc. and Kansas Department of Corrections the following confidential information:

- ☐ Physician/Provider's summary of my diagnosis, medications, treatments, prognosis and recent care
- ☐ Admission ☐ Discharge ☐ Operative Summary Reports
- ☐ X-Ray ☐ Special Studies Reports ☐ HIV Test
- ☐ Laboratory Reports ☐ Immunization History ☐ Dental Treatment Records
- ☐ Psychiatric Summary Report ☐ Drug Treatment History & Counseling Reports

☒ Other Records ER visits
(Specify information requested)

This authorization shall remain in full force and effect until withdrawn in writing by me. I hereby release and agree to hold provider harmless from any and all liability that may result from such release of information.

James Monroe
(Patient's Signature)

9-12-06
(Date)

Rufus Corby
(Witness Signature)

9/12/06
(Date)

The information requested is recognized as confidential and will be used only to ensure prompt and appropriate treatment of the named patient.

(Signature and Title for PHS)

(Date)

 *** TX REPORT ***

TRANSMISSION OK

JOB NO. 1413
 DESTINATION ADDRESS 92862406
 PSWD/SUBADDRESS
 DESTINATION ID
 ST. TIME 09/12 14:53
 USAGE T 00'18
 PGS. 1
 RESULT OK



DEPARTMENT OF CORRECTIONS

AUTHORIZATION FOR RELEASE OF INFORMATION

To: Baptist South From: SHC

Elmore

Patient: Monroe James Inmate ID No.: 167435 SCC

Alias: _____ Social Security No.: 418 . 94 . 4089

Date of Birth: 9/8/67 Date(s) of Service: 9-4-06

I hereby authorize the above named provider to release to Prison Health Services, Inc. and Kansas Department of Corrections the following confidential information:

- | | |
|---|--|
| <input type="checkbox"/> Physician/Provider's summary of my diagnosis, medications, treatments, prognosis and recent care | |
| <input type="checkbox"/> Admission | <input type="checkbox"/> Discharge |
| <input type="checkbox"/> X-Ray | <input type="checkbox"/> Special Studies Reports |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Immunization History |
| <input type="checkbox"/> Psychiatric Summary Report | <input type="checkbox"/> Drug Treatment History & Counseling Reports |
| <input checked="" type="checkbox"/> Other Records <u>ER visits</u> | |

(Specify information requested)

ST
RATTVILLE
280-2843
244-8448
361-4239

B0624700398 MONROE, JAMES
DOB: 09/08/67 Age: 38Y MR #: 709779
Admit Date/Time: 09/04/06 2151P
915 FALERO, WALLACE G

ptist
LTH

ER PRESCRIPTION & DISCHARGE INSTRUCTION

Page 1 of 3

PRESCRIPTION FORM

Weight	Phone	Allergies	Loca SOU
MEDICINES PRESCRIBED		If non, check this box: <input type="checkbox"/>	VOID IF NOT PRINTED WITH CRANBERRY BACKGROUND

Name/Strength;	Number	Schedule / Duration	No Refills	Refills
1. <i>Kodex 600mg</i>	<i>#40</i>	<i>1 QID x 10 days</i>	<input checked="" type="checkbox"/>	
2. <i>Lorazepam 2.5mg</i>	<i>#12</i>	<i>1 QID x 10 days</i>	<input checked="" type="checkbox"/>	
3. <i>[scribble]</i>			<input type="checkbox"/>	
4. <i>[scribble]</i>			<input type="checkbox"/>	
5. <i>[scribble]</i>			<input type="checkbox"/>	

Dante DeJesus
DEA - BD 9322063
AL 26777

Joel Sullivan
DEA - AS2020066
ARN - 10094

Ronald A. Shaw
DEA - BR2471326
AL - 6388

Julio Enrico Rios
DEA - BR2471326
ARN - 21678

Wallace Falero
DEA - AF1692119
AL - 9405

James M. Bradwell
DEA - BB6422086
AL - 22767

David G. Alexander
DO - 657
AA3259226

John Moorehouse
DEA - AM6869119
ARN - 7151

Jessie Austin
DEA - AD8394075
ARN - 8595

Julian Mahaganasan
DEA - BM7657121
AL 24516

George Smith
DEA AS2179706
AL 11413

James Thomas
DEA - BT3642938
DO 374

Victoria L. Beckman
DEA - BB6253885
AL - 22440

Carlos Gutierrez
DEA - BG6616203
AL 24653

Joshua Kotouc
DEA - BK9526724
AL 26943

James Matic
DEA BM3360536
AL 17681

David Hines
DEA BH2531160
AL 22703

LABEL ALL PRESCRIPTIONS

No Refills

Product Selection Permitted

M.D./D.O.

M.D./D.O.

Dispense as Written

Follow up to PMD staples out 7-10 days

Referred to:

- ☐ Dr. _____
Phone: _____
☐ Call on next business day for follow-up appointment
in _____ days / weeks ☐ Next available

- ☐ Return to Emergency Dept in _____ hours / days for recheck.
☐ If no improvement or your condition worsens, call your private physician or return to the Emergency Department for a recheck.
☐ Learning needs assessed ☐ Instructions Modified _____
☐ Education provided on new Medication _____

I understand that the treatment I have received was rendered on an emergency basis and is not meant to replace complete care from a primary care provider or clinic. Furthermore, I have been released before all of my medical problems were apparent, diagnosed, and/or treated. If my condition worsens, I have been instructed to call my primary care provider or return to this facility or the nearest emergency center. I understand that I should NOT drive or perform hazardous tasks if my medication or treatment causes drowsiness. I have read and understand the above, received a copy of this form and applicable instruction sheets, and I will arrange for follow-up care. If diagnostic tests indicate a need for modification in therapy, you will be notified at the phone number you provided.

- ☒ Patient
☐ Relative
☐ Other _____

Time Released: >

0200 HRS

INSTRUCTED BY:

PHYSICIAN:

WORK/SCHOOL STATEMENT from the Emergency Department

DATE

PATIENT

- ☐ Patient was seen by Dr. _____
☐ No athletics / physical education: _____ days
☐ May return to work/school without restrictions
☐ Will require time off work / school. Estimated time: _____ days*
☐ Must be reevaluated by family / occupational physician before returning to school / work.

- ☐ May return to restricted duties for _____ days*
Restrictions: _____
☐ _____ was here with relative/child.
☐ Other _____

Time off from school or work longer than three days should be approved by a Personal or Company/Occupational Medicine Physician, unless otherwise stated.



ER 160

EMERGENCY

028974

ADMISSION DATE 3/4/06		TIME 740 AM <input checked="" type="radio"/> PM	ORIGINATING FACILITY Station		<input type="checkbox"/> SICK CALL <input type="checkbox"/> EMERGENCY <input checked="" type="checkbox"/> OUTPATIENT																									
ALLERGIES NKA			CONDITION ON ADMISSION <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR <input type="checkbox"/> SHOCK <input type="checkbox"/> HEMORRHAGE <input type="checkbox"/> COMA																											
VITAL SIGNS: TEMP 98.9		ORAL RECTAL	RESP. 20		PULSE 96	B/P 160/96																								
NATURE OF INJURY OR ILLNESS I- I was just sitting watching TV when somebody came and started stabbing people. O- NOX3. Skin w/ deep laceration. Noted 2.5cm stab wound on @ side of spine below shoulder blades. @ drainage at present. 1cm laceration @ @ elbow & blood flow @ slow rate. C/O pain when asked to take a deep breath to check lung sounds. Pain continuous. A- Manual punched wound. p- Reported to Rm Corbin To be sent to Bapt So ER via van.			<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>ABRASION ///</td> <td>CONTUSION #</td> <td>BURN xx xx</td> <td>FRACTURE Z Z</td> <td>LACERATION / SUTURES</td> </tr> </table> <div style="text-align: center;"> </div>				ABRASION ///	CONTUSION #	BURN xx xx	FRACTURE Z Z	LACERATION / SUTURES																			
ABRASION ///	CONTUSION #	BURN xx xx	FRACTURE Z Z	LACERATION / SUTURES																										
PHYSICAL EXAMINATION			<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>ORDERS / MEDICATIONS / IV FLUIDS</td> <td>TIME</td> <td>BY</td> </tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </table>				ORDERS / MEDICATIONS / IV FLUIDS	TIME	BY																					
ORDERS / MEDICATIONS / IV FLUIDS	TIME	BY																												
DIAGNOSIS																														
INSTRUCTIONS TO PATIENT																														
DISCHARGE DATE 3/4/06		TIME AM PM	RELEASE / TRANSFERRED TO <input checked="" type="checkbox"/> DOC <input type="checkbox"/> AMBULANCE <input type="checkbox"/>		CONDITION ON DISCHARGE <input type="checkbox"/> SATISFACTORY <input type="checkbox"/> POOR <input type="checkbox"/> FAIR <input type="checkbox"/> CRITICAL																									
NURSE'S SIGNATURE [Signature]		DATE	PHYSICIAN'S SIGNATURE		CONSULTATION																									
INMATE NAME (LAST, FIRST, MIDDLE) MONROE, JAMES				DOC# 167435	DOB 9/8/67	R/S Btm																								
				FAC. Sec																										

Prison Health Services

REFUSAL OF TREATMENT FORM

Institution: StationResident's Name: Monroe, James K. ID# 167435D.O.B. 9-8-67I, _____ have, this day, knowing that I have a condition
(Name of Inmate)

requiring medical care as indicated below:

A. Refused medication.

E. Refused X-Ray services.

B. Refused dental care.

F. Refused other diagnostic tests.

C. Refused an outside medical appointment.

G. Refused physical examination.

D. Refused laboratory services.

H. Other (Please specify)

Reason For Refusal

No Show for MD appt 7/26/06

Potential Consequences Explained

I acknowledge that I have been fully informed of and understand the above treatment recommendations and the risks involved in refusing them. I hereby release and agree to hold harmless the state, statutory authority, all correctional personnel, medical/health personnel from all responsibility and any ill effects which may result from this refusal and I shall personally assume responsibility for my welfare.

I have read this form and certify that I understand its contents.

Witness Signature

Witness Signature

Date

Patient Signature

Time

NOTE: A refusal by the resident to sign requires the signatures of at least one witness in addition to that of the medical staff member.



Informed Consent to Medical Services

Inmate's Name: MONROE, James 167435
 Date of Birth: 9/8/67 Social Security No.: _____
 Date: 7/12/06 Time: 230 A.M.
P.M.

I hereby authorize Prison Health Service, Inc. and Dr. J. Pearson,
 (Print Physician's Name)

his assistant(s) or designee(s) to treat me as is necessary in his judgement.

The procedure(s), Wart removal, necessary to treat my condition has been fully ex-
 (state in Layman's terms)

plained to me by Dr. Pearson and I understand the nature of, and risks associated
 with, this procedure(s). Briefly stated, they are: (Benefits) _____

Remove wart, but it may return

(Risks) Skuller - infection & scar at site of
wart removal.

I am aware that the practice of the medical sciences is not exact and I acknowledge that no guarantees have been made to me as to the results of this procedure(s). Alternate treatment methods and their consequences as well as the risks of refusing the described treatment(s) (if applicable) have been fully explained to me.

James Monroe
 (Signature of Inmate)

[Signature]
 (Witness)

[Signature]
 (Signature & Title of Provider)

 (Witness)



SPECIAL NEEDS COMMUNICATION FORM

Date: 6-14-06

To: Staton

From: HCU

Inmate Name: Monroe, James ID#: 167435

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

① work stop X 2 hours - 6-14 through 6-17-06
No recreation or weight lifting X 30 days

Date: 6-14-06 MD Signature: D. Pearson / S. Taylor Time: 12:19pm

Prison Health Services

REFUSAL OF TREATMENT FORM

Institution: ElmoreResident's Name: Mourae, JamesID# 167 435D.O.B. 09/08/67I, James Mourae
(Name of Inmate)

have, this day, knowing that I have a condition

requiring medical care as indicated below:

☐ A. Refused medication.☐ E. Refused X-Ray services.☐ B. ~~Refused dental care.~~☐ F. ~~Refused other diagnostic tests.~~☐ C. Refused an outside medical appointment.☐ G. Refused physical examination.☐ D. Refused laboratory services.☒ H. Other (Please specify)Reason For Refusal I shouy sick call

Potential Consequences Explained _____

I acknowledge that I have been fully informed of and understand the above treatment recommendations and the risks involved in refusing them. I hereby release and agree to hold harmless the state, statutory authority, all correctional personnel, medical/health personnel from all responsibility and any ill effects which may result from this refusal and I shall personally assume responsibility for my welfare.

I have read this form and certify that I understand its contents.

Witness Signature

Witness Signature

Date

Patient Signature

Time

NOTE: A refusal by the resident to sign requires the signatures of at least one witness in addition to that of the medical staff member.



PRISON
HEALTH
SERVICES
INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 1/25/06

To: Elmore

From: STCU

Inmate Name: Montae James ID#: 167435

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

WORK Stop for 5
days 1/24, 27, 28, 29, 30/06

Date: 1/25/06 MD Signature: Dr. Pleasant/Mulligan JMD Time: 2200



SPECIAL NEEDS COMMUNICATION FORM

Date: 1/11/06

To: Elmore

From: SHCU

Inmate Name: Monroe James ID#: 167435

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

Work Stop x 3 days 1/12/06 - 1/14/06

Date: 1/11/06

MD Signature: Lester / Smulligan

Time: 2:00

Prison Health Services

REFUSAL OF TREATMENT FORM

Institution: Elmore Correctional CenterResident's Name: James Kelly Monroe ID# 167435D.O.B. 9/8/67I, James Kelly Monroe have, this day, knowing that I have a condition
(Name of Inmate)

requiring medical care as indicated below:

- | | |
|---|---|
| <input type="checkbox"/> A. Refused medication. | <input type="checkbox"/> E. Refused X-Ray services. |
| <input type="checkbox"/> B. Refused dental care. | <input type="checkbox"/> F. Refused other diagnostic tests. |
| <input type="checkbox"/> C. Refused an outside medical appointment. | <input type="checkbox"/> G. Refused physical examination. |
| <input type="checkbox"/> D. Refused laboratory services. | <input checked="" type="checkbox"/> H. Other (Please specify) |

No Show for Sick Call

Reason For Refusal _____

Potential Consequences Explained _____

I acknowledge that I have been fully informed of and understand the above treatment recommendations and the risks involved in refusing them. I hereby release and agree to hold harmless the state, statutory authority, all correctional personnel, medical/health personnel from all responsibility and any ill effects which may result from this refusal and I shall personally assume responsibility for my welfare.

I have read this form and certify that I understand its contents.

[Signature]
Witness Signature

Witness Signature _____

Date 1/16/08

Patient Signature _____

Time 6:00 PM

NOTE: A refusal by the resident to sign requires the signatures of at least one witness in addition to that of the medical staff member.

Elmore Correctional Facility:

Sick call is performed at 7:00 am in the internal visitation yard Monday through Friday. All completed sick call requests and grievances must be placed in the locked sick call request box located beside the pill call window. All sick call requests must be completed and turned by 2:30 pm daily.

Pill call is performed three times a day from the pill call room located beside the shift office at the times stated below. Pill call is subject to change by health care unit and security.

1. Morning pill call: 4:00 am
2. Noon pill call: 11:00 am
3. Evening pill call: 5:30 pm

Any dental, medical, or mental health educational information can be obtained through a written request to the Health Services Administrator.

I have had the opportunity to ask questions concerning the above information, and I have received a copy.

Inmate Signature: Jane Marie

Date: _____

Nurse Signature: C. Hellyer

Date: 4/14/08

Access to Care
Prison Health Services
Alabama Department of Corrections

Incarcerated individuals are afforded timely access to care to meet their serious medical, dental and mental health needs in each health care unit.

In emergency situations you are to advise the nearest correctional officer for immediate health services activation.

Inmates in population areas may fill out a routine sick call request form and place the completed form in the sick call collection locked box conveniently located in your facility for daily medical collection and routing to the correct health division.

Population, weekend and holiday sick call written request are reviewed by nurse triage staff each day - weekends and holidays. Those identified as unable to medically wait for the next routine and scheduled nurse triage will be located for necessary assessment. Those found able to wait for the next regularly scheduled nurse triage encounter will be forwarded for review during normal operating hours.

Inmates in lock down or single cells (segregation) may give their sick call request daily to nursing service. You will be contacted within a 24 hour timeframe barring extenuating circumstances.

Incarcerated individuals are not punished for seeking care for their serious health needs.

You will not be denied access to care or care services by medical staff based on any inability to meet co-pay assessments. There is no charge for physicals as scheduled by medical staff, chronic care, medical initiated care, follow-up care (to include test results) or public health care needs.

Inmate health care encounters in each institution are set in accordance with institutional requirements as approved by the Warden.

Medical grievance forms concerning health services may be obtained in the same manner as sick call request forms and returned to health services in the same manner. In segregation you may also ask a correctional officer for a medical grievance form and return the completed form to the officer for forwarding to the unit Health Services Administrator for review. If you are unable to resolve the initial grievance submitted you will be issued a formal grievance for completion by the Health Services Administrator. This form is to be returned to the Health Services Administrator at your site. Grievances are reviewed within three days of receipt.

If you are eligible for our Keep on Person medication program you will be advised and offered the opportunity to participate.

Some over the counter medications are available to you in the canteen. Over the counter medications are not issued from health services as Keep on Person medication.

Medical staff is unable to release your health information to family members.

If you initiate a medical care encounter and are scheduled an appointment for medical or dental services, you are expected to keep your appointment or sign a release of liability form prior to the scheduled encounter. Medication is to be taken as ordered. If you miss your medication you are subject to a counsel by medical staff. Your medical care is important. This is a joint effort between the patient, department of corrections and Prison Health Services.

Your assigned institution will provide you a copy of pill call times, sick call times and other unit specific information you should be aware of.

IDENTIFICATION OF SPECIAL NEEDS

NAME (PLEASE PRINT)

LAST

FIRST

MI

DATE OF BIRTH

SS#

Housing Recommendations:

General Population ☒

Medical Observation Unit ☐

Lower Level/Lower Bunk ☐

Suicide Precautions ☐

Special Watch (15 Minute Checks) ☐

Isolation ☐

Initiate Universal Precautions ☐

Individual found to be:

Frail/Elderly ☐

Physically Handicapped ☐

Developmentally Disabled ☐

Drug/Alcohol Withdrawal ☐

Special Mental Health Needs ☐

Expressed Suicidal Ideation ☐

History of Seizures ☐

Other ☐

Specify

Nurse

Date

RECEIVING SCREENING FORM

INMATE'S NAME: MUNROE, JAMES DATE: 3/4/05 TIME: 10:45 AM
 DOB: 9/8/67 OFFICER: Daniel Moore INSTITUTION: KILBY

RECEIVING OFFICER'S VISUAL OPINION

	YES	NO
Is the inmate conscious?	<u>4</u>	<u>—</u>
Does the inmate have any obvious pain or bleeding or other symptoms suggesting the need for doctor's care?	<u>—</u>	<u>4</u>
Are there any visible signs of trauma or illness requiring immediate emergency or doctor's care?	<u>—</u>	<u>4</u>
Any obvious fever, jaundice, or other evidence of infection which might spread through the institution?	<u>—</u>	<u>4</u>
Is the skin in poor condition or show signs of vermin or rashes?	<u>—</u>	<u>4</u>
Does the inmate appear to be under the influence of alcohol, or drugs?	<u>—</u>	<u>4</u>
Are there any signs of alcohol or drug withdrawal? (Extreme perspiration, shakes, nausea, pinpoint pupils, etc.)	<u>—</u>	<u>4</u>
Is the inmate making any verbal threats to staff or other inmates?	<u>—</u>	<u>4</u>
Is the inmate carrying any medication or report that he is on any medication which must be continuously administered or available?	<u>—</u>	<u>4</u>
Does the inmate have any obvious physical handicaps?	<u>—</u>	<u>4</u>

FOR THE OFFICER

Was the new inmate oriented on sick/dental call procedures?

This inmate was X a. Released for normal processing
— b. Referred to health care unit
— c. Immediately sent to the health care unit.

Daniel Moore
 Officer's Signature

This form will be completed at receiving and will be filed in the inmate's medical jacket to comply with NCCH Standards.



PHYSICIANS' ORDERS

NAME:

D.O.B. / /

ALLERGIES:

Use Last

Date / /

DIAGNOSIS (If Chg'd)

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

DIAGNOSIS (If Chg'd)

D.O.B. / /

ALLERGIES:

Use Fourth

Date / /

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

DIAGNOSIS (If Chg'd)

D.O.B. / /

ALLERGIES:

Use Third

Date / /

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

DIAGNOSIS (If Chg'd)

NAME:

D.O.B. 9/11/06

ALLERGIES: NKA

Use Second

Date

9/11/06

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

DIAGNOSIS

NAME: Monroe, James

D.O.B. 9/18/67

ALLERGIES: NKA

se First

Date

9/18/06

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

MEDICAL RECORDS COPY

Percozine 2 PO Q 80 PM - 7 days
 9/20/06 1530

Bonadryl 25 mg T PO BID X 3 days



PHYSICIANS' ORDERS

NAME:

Monroe, James

D.O.B.

9, 18, 06

ALLERGIES:

NKA

Use Last

Date

9, 15, 06

DIAGNOSIS (If Chg'd)

D/C to Station.

Lortab 5/500mg TID PO Q 4-6 PM X 3

1100 in 57 days

Lortab 5/500mg TID PO qigem

9-11-06 Monroe

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME:

Monroe, James
167435

D.O.B.

9, 18, 67

ALLERGIES:

NKA

Use Fourth

Date

9, 05, 06

DIAGNOSIS (If Chg'd)

Lortab 5mg TID PO Q 4-6 PM for 1

Reflex 500mg TID PO Q 10 X 10 days

PO-Pr Carbier / Q. White pri

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME:

Monroe, James
167435

D.O.B.

9, 18, 67

ALLERGIES:

NKA

Use Third

Date

7, 12, 06

DIAGNOSIS (If Chg'd)

Hew Unit to V site

of work removal

in 24h

7/26/06 Monroe

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME:

Monroe, James

D.O.B.

9, 18, 67

ALLERGIES:

NKA

Use Second

Date

6, 14, 06

DIAGNOSIS (If Chg'd)

Meds. Taylor VCN 6-14-06 12:40pm

No recreation or weight

lifting X 30 days

Molam 600mg PO TID X 3 days

V.O. Dr. Pleasant / S. Taylor VCN

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME:

Monroe, James
#167435

D.O.B.

9, 18, 67

ALLERGIES:

Use First

Date

4, 18, 06

DIAGNOSIS

Hpt. & M.P. / 11:00 PM for

evaluation & tx of hand

stroke moving

V.O. Dr. Pleasant / 2 P.M. / 11:00 PM

☐ GENERIC SUBSTITUTION IS NOT PERMITTED



PHYSICIANS' ORDERS

NAME:

DIAGNOSIS (If Chg'd)

D.O.B. / /

ALLERGIES:

Use Last Date / /

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Monroe, James

DIAGNOSIS (If Chg'd)

D.O.B. 9, 8, 67 ECC

ALLERGIES: NKDA

Use Fourth Date 3/2/06

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Monroe, James

DIAGNOSIS (If Chg'd)

D.O.B. 9, 8, 67

ALLERGIES: NKDA

Use Third Date 2/22/06

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Monroe, James

DIAGNOSIS (If Chg'd)

D.O.B. 9, 8, 67

ALLERGIES: NKDA

Use Second Date 2/16/06

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Monroe, James

DIAGNOSIS

D.O.B. 9, 8, 67

ALLERGIES: NKDA

Use First Date 2/7/06

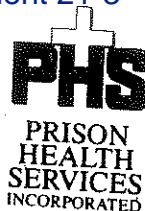
☐ GENERIC SUBSTITUTION IS NOT PERMITTED

Matrin 600mg tid x 3 days
Kop noon dose
Note
Call for 3/3/06 0200

Ko Hep 500mg bid x 7 days
Matrin 600mg tid x 5 days
Kop noon dose

Penicillin VK 500mg bid x 7 days
Metoprolol 50mg bid x 5 days
Kop noon dose

Matrin 600mg tid x 5 days
Kop noon dose



PHYSICIANS' ORDERS

NAME: MONROE, JAMES
167435

D.O.B. 9/8/67

ALLERGIES: NKA

Use Last Date 2/3/06

DIAGNOSIS (If Chg'd) Adj. 2/0 to depressed mood
D/C Prozac (tm med noncompliant)
(tm refusing meds)

Noted 2-3-06 425 SRanney, MD.
J. Sullivan

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Monroe, James
167435

D.O.B. 9/8/67

ALLERGIES: NKA

Use Fourth Date 1/24/06

DIAGNOSIS (If Chg'd)

(5) Give profile for work stop
for 5 days

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Monroe, James
167435

D.O.B. 9/8/67

ALLERGIES: NKA

Use Third Date 1/24/06

DIAGNOSIS (If Chg'd)

(1) urine dip stick - done

(2) urine C&S

(3) Give work stop X 5 days

(4) HCU visit in 2-3 wk to V

(5) Hand wait

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Monroe, James
167435

D.O.B. 9/8/67

ALLERGIES: NKA

Use Second Date 1/10/06

DIAGNOSIS (If Chg'd)

(5) work stop X 3 days

(6) HCU visit 2 wk + V wait

(1) UA in house - done

(2) Urine C&S - done 008417

(3) Chlamydia & GC - Proct 0964794

(4) Testicular support brace X 60 days

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: MONROE, James
167435 - ELMORE

D.O.B. 9/8/67

ALLERGIES: NKA

Use First Date 1/6/05

DIAGNOSIS

UA in house today - Results same

HCU visit Re Urine/proctal problems

Bactrim DS po B/D X 10 days

1st dose given

☐ GENERIC SUBSTITUTION IS NOT PERMITTED



PHYSICIANS' ORDERS

NAME: Monroe, James
167435

D.O.B. 9/8/67

ALLERGIES: NKDA

Use Last Date 12/20/05

DIAGNOSIS (If Chg'd)

Adj. 7/6 to Dep. mood
Prozac 20 mg. po. q AM x 90 days

Seamen, MD

Noted 12/20/05 8:15 - A. Small tm

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Monroe, James
167435

D.O.B. 9/8/67

ALLERGIES:

Use Fourth Date 5/9/05

DIAGNOSIS (If Chg'd)

CH4636 - Hepatic profile

~~for 3/10/05~~
~~for 3/10/05~~

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Monroe, James
167435

D.O.B. 09/08/67

ALLERGIES: NKDA

Use Third Date 8/28/05

DIAGNOSIS (If Chg'd)

3-10-05
Calcium acid lig 1720
Apply GHS to waist - avoid
8:30 am applying to healthy tissue. KOP
KOP clasp

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Monroe, James
167435

D.O.B. 9/8/67

ALLERGIES: NKDA

Use Second Date 3/7/05 2pm

DIAGNOSIS (If Chg'd)

Td 0.5cc IM x 1

10m Webb CRNP / Hardy m

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Monroe, James
167435

D.O.B. 9/8/67

ALLERGIES: NKDA

Use First Date 3/7/05 1pm

DIAGNOSIS

CCC - TB

INH 300mg po qd x 31 days

R 25mg po qd x 31 days

Profile 12, CK, EKG

CMF, CHO 1/0 m Webb CRNP / Hardy m

☐ GENERIC SUBSTITUTION IS NOT PERMITTED



Date/Time

Inmate's Name:

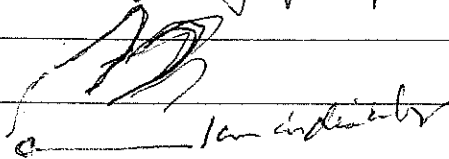
9/11/06
105

2046 re. removal of staples Wt 180 T-97° P-74
 R-20 025wt 97% B/p 130/70 ——— D. fur
~~Good~~ Staples removed from upper
 back & Elbows.
 PT. c/o acute (R) rib cage pain

Plan

motion for a few days.
 If no better,
 X-Ray of Rib cage.

① ② head wart c signs of pt picking on wart



LoS - virus @ glo + protein

① ② thin warts wart B head

P - U A ① & notes

- thin C + G

- made plant

see order

wk stop 45 days

[Signature]

Remove: made plant 45 days

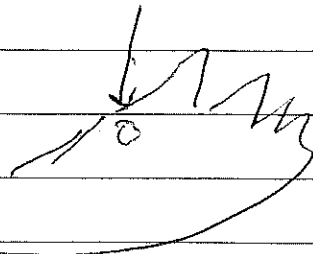
7/12/06
12P

204CP re: eval had (U) WT 176 T-97° P-62

R-20 025A 97° B/P 126/94 — *[Signature]*

① ② head wart - recurrent

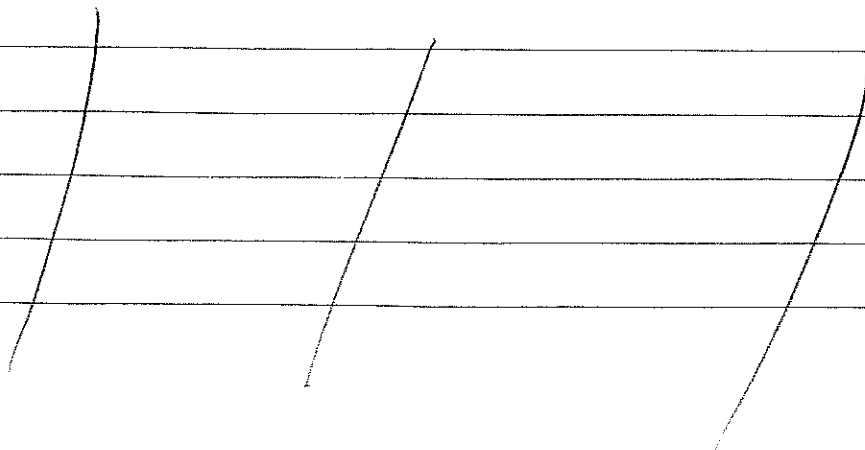
① 1cm diameter wart



① wart ② head dorsal scarfs

① wart - buried today

[Signature]







PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Print Name: JAMES MONROE Date of Request: 9/18-06
 ID # 167435 Date of Birth: 9/18/67 Location: B-2-16-B
 Nature of problem or request: DR SANTANA IM HAVING PROBLEMS SLEEPING
AFTER BEING STABBED IN THE BACK IN PARAMARIC AID AT N.Y. WHEN
THEY TURN 1.942 ON MY HEART GET TO BEATING REAL FAST IN A
NOISE UP SETS ME. I STAY IN FEAR. I NEED TO SEE YOU ASAP.
James Monroe
 Signature

DO NOT WRITE BELOW THIS LINE

Date: / /
 Time: AM PM
 Allergies:

RECEIVED	
Date:	<u>9-18-06</u>
Time:	<u>4:50P</u>
Receiving Nurse Initials	<u>OK</u>

(S)ubjective:

(O)bjective (V/S): T: P: R: BP: WT:

(A)ssessment:

(P)lan: Scheduled For MH Clinic
9-26-06

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

[Signature]
 SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

EMERGENCY

ADMISSION DATE 8/9/06		TIME 2:45 PM	ORIGINATING FACILITY STATION		<input type="checkbox"/> SICK CALL <input checked="" type="checkbox"/> EMERGENCY <input type="checkbox"/> OUTPATIENT													
ALLERGIES NKA			CONDITION ON ADMISSION <input checked="" type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR <input type="checkbox"/> SHOCK <input type="checkbox"/> HEMORRHAGE <input type="checkbox"/> COMA															
VITAL SIGNS: TEMP 98.2		CORAL RECTAL	RESP. 20	PULSE 94	B/P 137/92	RECHECK IF SYSTOLIC <100> 50												
NATURE OF INJURY OR ILLNESS <p>"My back went out on me again. I tried to pull up on the bed with my hands. My lower back and left leg hurt. (Points to V Back). My leg is throbbing."</p> <p>Inmate walked into HCU without assistance,</p>			<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>ABRASION ///</td> <td>CONTUSION #</td> <td>BURN ^{xx} _{xx}</td> <td>FRACTURE ^Z _Z</td> <td>LACERATION / SUTURES</td> </tr> </table>				ABRASION ///	CONTUSION #	BURN ^{xx} _{xx}	FRACTURE ^Z _Z	LACERATION / SUTURES							
			ABRASION ///	CONTUSION #	BURN ^{xx} _{xx}	FRACTURE ^Z _Z	LACERATION / SUTURES											
PHYSICAL EXAMINATION <p>O₂ sat 97%. Guarded movements. Pedal pulses good. No edema. No tenderness with palpation to back, @ toes warm to touch, cap. refill WNL, VS WNL, I/M removed shoes & socks without assistance. I/M able to raise leg into lap & bend over to put shoes & socks back on. A - Alteration in comfort R/T back pain.</p>			<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>ORDERS / MEDICATIONS / IV FLUIDS</td> <td>TIME</td> <td>BY</td> </tr> <tr> <td>Pain in lower back T1d PRN x 480</td> <td></td> <td></td> </tr> <tr> <td>met S. Taylor 8:10pm</td> <td></td> <td></td> </tr> <tr> <td>per protocolic pp/S Taylor</td> <td></td> <td></td> </tr> </table>				ORDERS / MEDICATIONS / IV FLUIDS	TIME	BY	Pain in lower back T1d PRN x 480			met S. Taylor 8:10pm			per protocolic pp/S Taylor		
ORDERS / MEDICATIONS / IV FLUIDS	TIME	BY																
Pain in lower back T1d PRN x 480																		
met S. Taylor 8:10pm																		
per protocolic pp/S Taylor																		
DIAGNOSIS Alteration in comfort R/T back pain																		
INSTRUCTIONS TO PATIENT Take meds - cool compress x 480 then heat PRN																		
DISCHARGE DATE 8/9/06		TIME 3:10 PM	RELEASE / TRANSFERRED TO <input checked="" type="checkbox"/> DOC <input type="checkbox"/> AMBULANCE <input type="checkbox"/>		CONDITION ON DISCHARGE <input checked="" type="checkbox"/> SATISFACTORY <input type="checkbox"/> POOR <input type="checkbox"/> FAIR <input type="checkbox"/> CRITICAL													
NURSE'S SIGNATURE S. Taylor RN 89-06		DATE 8/9/06	PHYSICIAN'S SIGNATURE		CONSULTATION													
INMATE NAME (LAST, FIRST, MIDDLE) Monroe, James			DOC# 167435	DOB 9/18/67	R/S B/m	FAC. SCC												



**PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST**

SK

Print Name: JAMES MONROE Date of Request: 6-12-06
 ID # 167435 Date of Birth: 9/8/62 Location: B-2-57
 Nature of problem or request: HURT MY LOWER BACK & MY LEFT LEG
IS GOING NUM, ALSO MY LEFT ARM IS GOING NUM
ALSO I HAVE SICK CALL ABOUT THIS WOUND ON MY HAND
I SEEN NURSE BUT NEVER CAME OUT ON NEW LETTER TO SEE DOCTOR
JAMES MONROE
 Signature

DO NOT WRITE BELOW THIS LINE

Date: / /
 Time: AM PM
 Allergies:

RECEIVED	
Date:	
Time:	
Receiving Nurse Initials	

(S)ubjective:

(O)bjective (V/S): T: P: R: BP: WT:

(A)ssessment:

g/c
6/15/06
ABN
9:14 AM

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()
 If Emergency was PHS supervisor notified: Yes () No ()
 Was MD/PA on call notified: Yes () No ()

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
 YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT
 GLF-1002 (1/4)



Nursing Evaluation Tool:

General Sick Call

Facility: Alabama Department of Corrections

Patient Name: Monroe James

Inmate Number: 167435

Date of Report: 6 15 06 MM DD YYYY

Date of Birth: 9 18 67 First MM DD YYYY MI

Time Seen: 9:14 AM/PM Circle One

Subjective: Chief Complaint(s): 2 mcs ago I hurt my back on the wt pik. I was climbing
up on my rack Tues mtd my back got hurt again. My @ leg
feels numb down to my toes. It tingles all the way to my toes.
 Brief History: Feels numb down to my toes. It tingles all the way to my toes.
 Pain Scale (8) Constant pain. Feels better to walk than lie down. @ pain = urination
to N/V. Does have pain with cough. Across lower lumbar. Good ROM to both
feet, both knees. Good equal strength in legs bilat. @ Growth the size
of dim on @ hand (Guarded movements).

☐ Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: 99.4 P: 74 RR: 12 B/P: 102/64

Examination Findings: Observed guarded movements with sitting and rising
from chair. Good ROM to Both legs, both knees, no Bruising/swelling
observed to back. Good strength in legs bilat.
Observed dim size to wt hand at Base of Thumb.

Advised Hot soaks to back 3x/day x 1wk, Not to wt lift
x 30 days

Assessment: (Referral Status) Preliminary Determination(s): ☐ Check Here if additional notes on back

☐ Referral NOT REQUIRED

☐ Referral REQUIRED due to the following: (Check all that apply)

☐ Recurrent Complaint (More than 2 visits for the same complaint)

☒ Other: Loss of sensation @ leg.

States was not on Newsletter 5/6/06 - Never saw MD as scheduled (MAY
Need rescheduling.)

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

☒ Instructions to return if condition worsens.

☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other:

OTC Medications given ☐ NO ☐ YES (If Yes List):

Referral: ☐ NO ☒ YES (If Yes, Whom/Where): HCU Review

Referral Type: ☐ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?):

Date for referral: 1 1 06 MM DD YYYY

Nurses Signature: A. Blakely RN

Name: A. Blakely RN

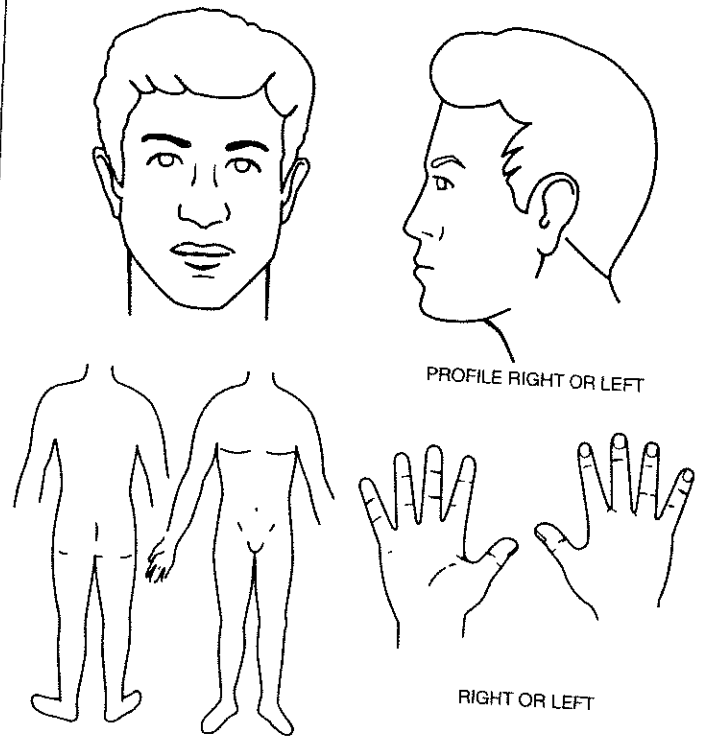
Printed

EMERGENCY

ADMISSION DATE 6/14/06 11:50 AM		TIME 11:50 AM	ORIGINATING FACILITY Station	<input type="checkbox"/> SICK CALL <input checked="" type="checkbox"/> EMERGENCY <input type="checkbox"/> OUTPATIENT
ALLERGIES NKA		CONDITION ON ADMISSION <input checked="" type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR <input type="checkbox"/> SHOCK <input type="checkbox"/> HEMORRHAGE <input type="checkbox"/> COMA		
VITAL SIGNS: TEMP 98.1		<input checked="" type="radio"/> ORAL <input type="radio"/> RECTAL	RESP. 18	PULSE 76 B.P. 128/74
NATURE OF INJURY OR ILLNESS		RECHECK IF SYSTOLIC <100> 50		

S) See net tools

ABRASION ///	CONUSION #	BURN xx xx	FRACTURE Z Z	LACERATION / SUTURES
--------------	------------	---------------	-----------------	-------------------------



PHYSICAL EXAMINATION

O) Sat 98% - see net tools

ORDERS / MEDICATIONS / IV FLUIDS

P) See orders

A) Altered in comfort

INSTRUCTIONS TO PATIENT

Apply heat to back PRN

DISCHARGE DATE 6/14/06 12:15 AM	TIME 12:15 AM	RELEASE / TRANSFERRED TO <input checked="" type="checkbox"/> DOC <input type="checkbox"/> AMBULANCE	CONDITION ON DISCHARGE <input checked="" type="checkbox"/> SATISFACTORY <input type="checkbox"/> POOR <input type="checkbox"/> CRITICAL	
NURSE'S SIGNATURE S. Taylor	DATE 6-14-06	PHYSICIAN'S SIGNATURE	DATE	CONSULTATION
INMATE NAME (LAST, FIRST, MIDDLE) Monroe James K.		DOC# 167435A-8-67	DOB 01/01/50	R/S blm

Facility: Staton Correctional Facility

Patient Name: Monroe

Inmate Number: 167435 Last James K

Date of Report: 6/14/06 MM DD YYYY

Date of Birth: 9/18/67 First Last

Time Seen: 10:50 AM/PM Circle One

Back Pain

Subjective: Chief Complaint(s): Back pain

Onset: last night getting on 1 neck & pulled my back

Pain Scale: (1-10) 8 ☒ New onset ☐ Chronic condition exacerbation

Location of Pain: lower back Type: ☐ Sharp ☐ Dull ☐ Intermittent ☒ Constant

History: Hurt back 2 months ago on weights Radiation of pain: ☐ No ☒ Yes to: to L leg Numbness: ☐ No ☒ Yes

(Continue on back if necessary)

Associated symptoms: Pain on urination? ☒ No ☐ Yes Increased urination? ☒ No ☐ Yes Nausea ☒ No ☐ Yes Vomiting ☒ No ☐ Yes

Pain with cough/breathing? ☒ No ☐ Yes

Check Here if additional notes on back

Objective: Vital Signs: (If Indicated) T: 98.1 P: 76 RR: 18 B/P: 128/74

Back Exam: ☐ Tender to touch ☐ Contusion ☐ Muscle spasms ☐ Impaired range of motion

Additional Findings: ☒ Numbness ☒ Tingling ☐ Abnormal gait ☒ Weakness of extremities ☐ Foot drop ☐ Other:

Elaborate positive findings: more back pain when bending over as if he were going to touch his toes

Lower extremities: ☒ Normal ☐ Abnormal (describe): Pedal pulses: ☒ Present ☐ Absent

Check Here if additional notes on back

Additional Examination: Strong pedal pulse @ foot, can stand erect, can walk & steady gait, no edema noted

Continue on back if necessary

Assessment: (Referral Status)

☒ Referral NOT Required

Preliminary Determination(s):

- ☐ Referral Required due to the following: (Check all that apply)
- ☐ Loss of sensation
 - ☐ Prior malignancy
 - ☐ Other:
 - ☐ Presence of RBCs from dipstick
 - ☐ Presence of WBCs from dipstick
 - ☐ Recurrent Complaint (More than 2 visits for the same complaint)

Plan:

- Check All That Apply: ☒ Work and recreation restrictions x 72 hours
- ☒ Education on avoiding back pain ☐ Education about stretching and back exercises. ☒ Instructions to return if condition worsens.
- ☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)
- Other: (Describe)

- ☐ Cold Compress (Acute injury) ☒ Warm Compress
- ☒ OTC Medications given ☐ NO ☐ YES (If Yes List): Motrin 600mg PO

Referral: ☒ NO ☐ YES (If Yes, Whom/Where):

Referral Type: ☐ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?):

Date for referral: 6/14/06 MM DD YY

x S. Taylor LPN

Nurse Signature

Name

Printed

S. Taylor LPN

Facility: Staten Correctional Facility
 Patient Name: Monroe, James
 Inmate Number: 167435 Last
 Date of Report: 4/18/06 AM DD YYYY
 Date of Birth: 9/8/67 First MI
 Time Seen: 1 AM AM PM Circle One

Subjective: Chief Complaint(s): _____
 Onset: 2 yrs. ago.

Brief History: _____
 (Continue on back if necessary)

Objective: Vital Signs: (As Indicated) T: 97.8 P: 112 RR: 18 BP: 20/80 ☐ Check Here if additional notes on back
 Examination Findings: O2 Sats. 98%
 (Continue on back if necessary)

Wart noted to top of hand. Inmate has been cutting on it. No being painful.

Assessment: (Referral Status) Preliminary Determination(s): Evaluation by M.D. / N.P. ☐ Check Here if additional notes on back
☐ Referral NOT REQUIRED
☒ Referral REQUIRED due to the following: (Check all that apply)
☐ Recurrent Complaint (More than 2 visits for the same complaint)
☐ Other: _____

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:
☐ Instructions to return if condition worsens.
☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)
☐ Other: _____

OTC Medications given: ☒ NO ☐ YES (If Yes List): _____

Referral: ☐ NO ☒ YES (If Yes, Whom/Where): M.D. / N.P.

Referral Type: ☐ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): _____ Date for referral: 4/18/06 AM DD YYYY Time _____

Signature: [Signature] Name: Nudy Robinson Printed



PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Print Name: JAMES MONROE Date of Request: 4-16-06
 ID # 167435 Date of Birth: 9/8/67 Location: B-2-5T
 Nature of problem or request: WOULD LIKE TO GET WART REMOVED
ITS REAL SORE HAVE USED PATCHES TOOK IT OFF
BUT CAME RIGHT BACK, NEED OF ON LEFT RISK

James Monroe
Signature

DO NOT WRITE BELOW THIS LINE

Date: / /
 Time: AM PM
 Allergies:

<p>RECEIVED</p> <p>Date: <u> </u></p> <p>Time: <u> </u></p> <p>Receiving Nurse Initials <u> </u></p>
--

(S)ubjective:

O₂ sats. @ 98%.

(O)bjective (V/S): T: 97.8 P: 12 R: 18 BP: 120/80 WT:

Wart noted to 1 hand (top) x 2 yrs. Has been cutting on it. Needs to be eval for being painful

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

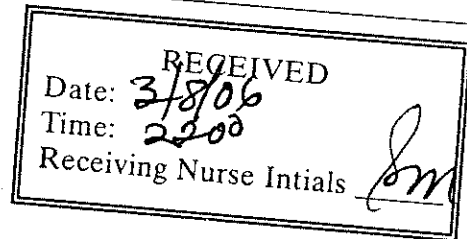
E/moe

Print Name: JAMES MONROE Date of Request: 3-8-06
ID # 167435 Date of Birth: 9/8-67 Location: B-2-61
Nature of problem or request: I would like to get a wart removed
from my R.S.S. I have already seen the doctor about it
but it keeps coming back. I also want like to see the
dentist about getting some teeth made.

[Signature]
Signature

DO NOT WRITE BELOW THIS LINE

Date: 3/8/06
Time: 2:00 AM PM
Allergies: _____



(S)ubjective:

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment:

[Signature]
03/09/06

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE

Check One: ROUTINE (☒) EMERGENCY ()
If Emergency was PHS supervisor notified: Yes () No ()
Was MD/PA on call notified: Yes () No ()

[Signature]

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Elmore

Print Name: JAMES MONROE Date of Request: 1-24-06
ID # 167435 Date of Birth: 9/8/67 Location: B-2-61
Nature of problem or request: STILL HAVING SAME PROBLEM WITH PEEING
ALSO WOULD LIKE TO HAVE WART REMOVED, I NEED
TO SEE DOCTOR

THANKS

James Monroe
Signature

DO NOT WRITE BELOW THIS LINE

Date: / /
Time: AM PM
Allergies:

RECEIVED
Date: <u> </u>
Time: <u> </u>
Receiving Nurse Initials <u> </u>

(S)ubjective:

(O)bjective (V/S): T: P: R: BP: WT:

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE () EMERGENCY ()
If Emergency was PHS supervisor notified: Yes () No ()
Was MD/PA on call notified: Yes () No ()

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT
GLF-1002 (1/4)



Nursing Evaluation Tool:

General Sick Call

Facility: BBB Elmore
 Patient Name: Monroe
 Inmate Number: 167435 Last
 Date of Report: 01 10 06 06
 Date of Birth: 09 10 67 MI
 Time Seen: AM PM Circle One

Subjective: Chief Complaint(s): Having problems urinating, sore rectum
 Onset: 3-4 months

Brief History: φ
 (Continue on back if necessary)

Objective: Vital Signs: (As Indicated) T: 99.0 P: 78 RR: 20 B/P: 130 170 Wgt 172
 Examination Findings: No burning a little bit upon urinating, small amount
Clear drainage noted to penis, φ lesions noted to rectum.
States "when I finish urinating, it continues on its' own."
Requests to see M.D.

Assessment: (Referral Status) Preliminary Determination(s):
☐ Referral NOT REQUIRED
☐ Referral REQUIRED due to the following: (Check all that apply)
☐ Recurrent Complaint (More than 2 visits for the same complaint)
☐ Other:

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:
☐ Instructions to return if condition worsens.
☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)
☐ Other:

OTC Medications given: ☒ NO ☐ YES (If Yes List):

Referral: ☐ NO ☒ YES (If Yes, Whom/Where): HCP

Referral Type: ☒ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?):

Date for referral: 01 10 06
 AM PM Time



PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

ECC

Print Name: JAMES MONROE Date of Request: 1-4-06
ID # 167435 Date of Birth: 9/8/67 Location: B-2-61
Nature of problem or request: HAVEING PROBLEM FEELING ADD RECTHOM
REAL SORE, CANT HARDLY WALK, RISK REAL SORE, WREST REAL SORE
ALSO HAS A COLD, WHEN I STOP FEELING IT BEGIN TO RUN ON ITS
ON.

JAMES MONROE
Signature

DO NOT WRITE BELOW THIS LINE

Date: 01/05/06
Time: (AM) PM
Allergies: NIL

RECEIVED
Date: _____
Time: _____
Receiving Nurse Initials _____

(S)ubjective:

(O)bjective (V/S): T: 99.0 P: 79 R: 20 BP: 130/70 WT: 172

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE

Check One: ROUTINE (✓) EMERGENCY ()
If Emergency was PHS supervisor notified: Yes () No ()
Was MD/PA on call notified: Yes () No ()

D Austin

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Print Name: JAMES MONROE Date of Request: 7-7-05
 ID # 167435 Date of Birth: 9/8/67 Location: B-2-61
 Nature of problem or request: I HAVE A WART ON MY HAND, THATS
BEING REMOVED, BUT I RUN OUT OF PATCHES, NEED
SOME MORE PATCHES. PLEASE ~~CONSIDER~~
ONE NURS AT STATION GAVE ME SOME BUT NOT ENOUGH
James Monroe
 Signature

DO NOT WRITE BELOW THIS LINE

Date: / /
 Time: AM PM
 Allergies:

RECEIVED	
Date:	<u>7/7/05</u>
Time:	<u>10:10 PM</u>
Receiving Nurse Initials	<u>SL</u>

(S)ubjective:

(O)bjective

(V/S): T:

F:

R:

BP:

WT:

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE
 Check One: ROUTINE () EMERGENCY ()
 If Emergency was PHS supervisor notified: Yes () No ()
 Was MD/PA on call notified: Yes () No ()

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: JAMES MONROE Date of Request: 7-5-05
ID # 167435 Date of Birth: 9/8-67 Location: B-2-61
Nature of problem or request: WOULD LIKE TO SEE DOCTOR OR NURSE TO GET
SOME MORE, WART REMOVER,

James Monroe
Signature

DO NOT WRITE BELOW THIS LINE

Date: / /
Time: AM PM
Allergies:

RECEIVED
Date: <u>7/6/05</u>
Time: <u>2:12 AM</u>
Receiving Nurse Initials: <u>JM</u>

(S)ubjective:

(O)bjective (V/S): T: P: R: BP: WT:

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

Dep 100

Facility Name: Staton

Month/Year of Charting: 9/06

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Lortab 5mg 1/1 po Q4-6 Prn x 3 days					X																										

Start Date: 9/5/06
Stop Date: 9/8/06

Prescriber: Corbier
RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Keflex 500mg 1/2 po QID x 10 days				X	X			X																							

Start Date: 9/5/06
Stop Date: 9/15/06

Prescriber: Corbier
RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Benadryl 25mg po Bid x 3 days																															

Start Date: 9/8/06
Stop Date: 9/11/06

Prescriber: Corbier
RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Percocet 1/2 po TID (78°) x 7 days																															

Start Date: 9/11/06
Stop Date: 9/18/06

Prescriber: Corbier
RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date:
Stop Date:

Prescriber:
RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date:
Stop Date:

Prescriber:
RX #:

Diagnosis	Nurse's Signature	Initial	Nurse's Signature	Initial	Documentation Codes
Allergies: <u>NKA</u>	<u>M. Dugg</u>	<u>MD</u>	<u>J. Parker</u>	<u>JP</u>	1. Discontinued Order 2. Refused 3. Patient out of facility 4. Charted in Error 5. Lock Down 6. Self Administered 7. Medication out of Stock 8. Medication Held 9. No Show 10. Other
Housing Unit:	<u>2363</u>	<u>82</u>	<u>11 Broyles</u>	<u>AB</u>	
Patient ID Number: <u>169435</u>					
Patient Name: <u>Monroe, James</u>					
Date of Birth: <u>9/12/11</u>					

Facility Name:	Month/Year of Charting:																																																																																																																																																																
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Lortab 5mg 1. PO Q4-6° PRN for pain x 5 days	<table border="1"> <tr><th>Hour</th><th>1</th><th>2</th><th>3</th><th>4</th><th>5</th><th>6</th><th>7</th><th>8</th><th>9</th><th>10</th><th>11</th><th>12</th><th>13</th><th>14</th><th>15</th><th>16</th><th>17</th><th>18</th><th>19</th><th>20</th><th>21</th><th>22</th><th>23</th><th>24</th><th>25</th><th>26</th><th>27</th><th>28</th><th>29</th><th>30</th><th>31</th></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </table>	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31																																																																																																																																
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Lortab 5 1/2 po Q4-6° PRN x 3 days	<table border="1"> <tr><th>Hour</th><th>1</th><th>2</th><th>3</th><th>4</th><th>5</th><th>6</th><th>7</th><th>8</th><th>9</th><th>10</th><th>11</th><th>12</th><th>13</th><th>14</th><th>15</th><th>16</th><th>17</th><th>18</th><th>19</th><th>20</th><th>21</th><th>22</th><th>23</th><th>24</th><th>25</th><th>26</th><th>27</th><th>28</th><th>29</th><th>30</th><th>31</th></tr> <tr><td>6A</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>12N</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>6P</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>12M</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </table>	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	6A																																12N																																6P																																12M																															
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Diagnosis	Nurse's Signature	Initial	Nurse's Signature	Initial	Documentation Codes
Allergies	NKA				1. Discontinued Order 2. Refused 3. Patient out of facility 4. Charted in Error 5. Lock Down 6. Self Administered 7. Medication out of Stock 8. Medication Held 9. No Show 10. Other
Housing Unit:					
Patient ID Number:					
Patient Name:	Monroe, James				
					Date of Birth: 9/8/67

Facility Name: <u>Staton</u>		Month/Year of Charting: <u>8/06</u>																														
Motrin 600mg PO Tid PRN x 5 days for back pain	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	6A																															
	12N																															
	6P																															
	Start Date: <u>8-9-06</u>	Prescriber: <u>Corbier</u>																														
	Stop Date: <u>8-13-06</u>	RX #:																														
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Start Date:	Prescriber:																														
	Stop Date:	RX #:																														
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Start Date:	Prescriber:																														
	Stop Date:	RX #:																														
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Start Date:	Prescriber:																														
	Stop Date:	RX #:																														
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Start Date:	Prescriber:																														
	Stop Date:	RX #:																														
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Start Date:	Prescriber:																														
	Stop Date:	RX #:																														
Diagnosis	Nurse's Signature	Initial	Nurse's Signature	Initial	Documentation Codes																											
Allergies: <u>NO KA</u>	<u>S. Taylor WPO</u>	<u>ST</u>			1. Discontinued Order 2. Refused 3. Patient out of facility 4. Charted in Error 5. Lock Down 6. Self Administered 7. Medication out of Stock 8. Medication Held 9. No Show 10. Other																											
Housing Unit:																																
Patient ID Number: <u>167435</u>																																
Patient Name: <u>Monroe</u>	<u>Jamas</u>	Date of Birth: <u>9-18-67</u>																														

Facility Name: Station Month/Year of Charting: 6/06

Motrin 600mg
PO Tid x 3 days

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
6A																														
12P																														
6P																														

St Start Date: 6-14-06 Prescriber: Pearson
Stop Date: 6-17-06 RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30

Start Date: Prescriber:

Stop Date: RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30

Start Date: Prescriber:

Stop Date: RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:

Stop Date: RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:

Stop Date: RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:

Stop Date: RX #:

Diagnosis	Nurse's Signature	Initial	Nurse's Signature	Initial	Documentation Codes
Allergies: <u>NKA</u>	<u>S. Taylor RN</u>	<u>ST</u>			1. Discontinued Order 2. Refused 3. Patient out of facility 4. Charted in Error 5. Lock Down 6. Self Administered 7. Medication out of Stock 8. Medication Held 9. No Show
Housing Unit:					
Patient ID Number: <u>167435</u>					
Patient Name: <u>Monroe</u>					

Month/Year of Charting: 3/06

Facility Name: *St. Mary's*

*propoc 20mg i
po qam*

Start Date: 12.22.95 Stop Date: 3.21.04 Prescriber: *[Signature]* RX #:

*Keflex 500mg
BID x 7 days*

Start Date: 2/24/06 Stop Date: 3/2/06 Prescriber: *Wright* RX #:

*Motrin 600mg
TID x 5 days
may give noon dose
KOP*

Start Date: 2/24/06 Stop Date: 3/02/06 Prescriber: *Wright* RX #:

*Motrin 600mg po
TID x 3(d)
NOON dose KOP*

Start Date: 3-2-06 Stop Date: 3-5-06 Prescriber: *Wright* RX #:

Diagnosis: *NKDA*

Allergies: *NKDA*

Housing Unit: *167435*

Patient ID Number: *167435*

Patient Name: *[Signature]*

Date of Birth: *9.8.67*

Nurse's Signature: *[Signature]* Initial: *MB*

Documentation:

1. Discontinued Ord
2. Refused
3. Patient out of fac
4. Charted in Error
5. Lock Down
6. Self Administered
7. Medication out c
8. Medication Held
9. No Show
10. Other

Facility Name: Elmore Correctional Facility		Month/Year of Charting: 02/06																														
Prozac 20MG Cap 30.00	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Take 1 capsule(s) by mouth in the morning	6A	<div style="position: relative; height: 100px;"> 6A DC'd 2/6/06 </div>																														
	MD	Start Date: 12-22-2005										Prescriber: Banerjee MIM, Sreelekha																				
		Stop Date: 03-21-2006										RX #: 251002666																				
Matrin 600mg tid po. tid x 5 days	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	6A	<div style="position: relative; height: 100px;"> 6A KOP 99999 </div>																														
	12N																															
	6P																															
	MD	Start Date: 02/07/06										Prescriber: Dr. Wright																				
		Stop Date: 02/12/06										RX #:																				
Pen VK 500mg tid x 7 days	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	6A	<div style="position: relative; height: 100px;"> 6A XX 99 99 99 </div>																														
	12N	<div style="position: relative; height: 100px;"> 12N XX 99 99 99 </div>																														
	6P	<div style="position: relative; height: 100px;"> 6P XX 99 99 99 </div>																														
KOP noon dose		Start Date: 2/16/06										Prescriber:																				
		Stop Date: 2/23/06										RX #:																				
Matrin 600mg tid x 5 days	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	6A	<div style="position: relative; height: 100px;"> 6A XX 99 99 99 </div>																														
	12N	<div style="position: relative; height: 100px;"> 12N XX 99 99 99 </div>																														
	6P	<div style="position: relative; height: 100px;"> 6P XX 99 99 99 </div>																														
KOP noon dose		Start Date: 2/16/06										Prescriber:																				
		Stop Date: 2/21/06										RX #:																				
Keftex 500mg BID x 7 days	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	6A	<div style="position: relative; height: 100px;"> 6A 999 </div>																														
	6P	<div style="position: relative; height: 100px;"> 6P 999 </div>																														
	MD	Start Date: 2/24/06										Prescriber: Wright																				
		Stop Date: 3/02/06										RX #:																				
Matrin 600mg tid x 5 days	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	6A	<div style="position: relative; height: 100px;"> 6A 999 </div>																														
	12N	<div style="position: relative; height: 100px;"> 12N 999 </div>																														
	6P	<div style="position: relative; height: 100px;"> 6P 999 </div>																														
KOP noon dose		Start Date: 2/24/06										Prescriber:																				
		Stop Date: 2/28/06										RX #:																				
Diagnosis	Nurse's Signature: [Signature] Initial: [Initial]																															
Allergies	Nurse's Signature: [Signature] Initial: [Initial]																															
Housing Unit:	Population: 167435																															
Patient ID Number:	167435																															
Patient Name:	Monroe, James																															
Date of Birth:	09-08-1967																															
1. Discontinued Order 2. Refused 3. Patient out of facility 4. Charted in Error 5. Lock Down 6. Self Administered 7. Medication out of Stock 8. Medication Held 9. No Show 10. Other																																

Facility Name: <u>Elmore</u>		Month/Year of Charting: <u>1/06</u>	
<u>Prozac 20mg + 10</u> <u>3 AM x 90 days</u>	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 <u>LA</u> <u>14</u> <u>09</u>		
	Start Date: <u>12/22/05</u> Prescriber: <u>Banajee</u> Stop Date: <u>3/22/06</u> RX #:		
<u>Bactrim DS po</u> <u>BID x 10 days</u>	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 <u>LA</u> <u>14</u> <u>09</u>		
	Start Date: <u>1/7/06</u> Prescriber: <u>Lussiter</u> Stop Date: <u>1/14/06</u> RX #:		
<u>Scrotal</u> <u>Support</u>	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 <u>gun</u> <u>1/13/06</u> <u>sm</u> <u>xp</u> <u>none</u>		
	Start Date: Prescriber: Stop Date: RX #:		
	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 (Empty grid)		
	Start Date: Prescriber: Stop Date: RX #:		
	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 (Empty grid)		
	Start Date: Prescriber: Stop Date: RX #:		
	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 (Empty grid)		
	Start Date: Prescriber: Stop Date: RX #:		
	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 (Empty grid)		
	Start Date: Prescriber: Stop Date: RX #:		
Diagnosis:	Doctor's Signature: <u>[Signature]</u> Initial: <u>SLB</u>	Nurse's Signature: Initial:	Documentation Codes: 1. Discontinued Order 2. Refused 3. Patient out of facility 4. Charted in Error 5. Lock Down 6. Self Administered 7. Medication out of Stock 8. Medication Held 9. No Show 10. Other
Allergies: <u>NRDA</u>			
Housing Unit: Patient ID Number: <u>167435</u> Patient Name: <u>Monroe, James</u>		Date of Birth: <u>9/8/67</u>	

Facility Name: ELMORE

PROZAC 20mg
PO q AM
x 90 days

Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30
Month/Year of Charting: 12/05

Start Date: 12/22/05Prescriber: B. WHEELERStop Date: 3/22/06

RX #:

Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

Start Date:

Prescriber:

Stop Date:

RX #:

Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

Start Date:

Prescriber:

Stop Date:

RX #:

Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Start Date:

Prescriber:

Stop Date:

RX #:

Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Start Date:

Prescriber:

Stop Date:

RX #:

Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Start Date:

Prescriber:

Stop Date:

RX #:

Diagnosis

Nurse's Signature

Initial

Nurse's Signature

Initial

Documentation Codes

Allergies UKDA

A. Small Jr DF

Housing Unit:

Patient ID Number: 167435

Patient Name:

Mouroe, James

Date of Birth:

02-11

1. Discontinued Order
2. Refused
3. Patient out of facility
4. Charted in Error
5. Lock Down
6. Self Administered
7. Medication out of Stock
8. Medication Held
9. No Show
10. Other

MEDICATION ADMINISTRATION RECORD

04/01/2005
STDT01

(KIL-445) KILBY CORRECTIONAL FAC

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
ISONIAZID (INH) 300MG TAB TAKE 1 TABLET(S) BY MOUTH DAILY																															
RX: 7064022 WEBB, H.P., MARTY, NP START - 03/09/2005 STOP - 04/08/2005 PYRIDOXINE (VIT B-6) 25MG TAB TAKE 1 TABLET(S) BY MOUTH DAILY																															
RX: 7064026 WEBB, H.P., MARTY, NP START - 03/09/2005 STOP - 04/08/2005 WART REMOVER (CPD W-DUOFIL) 17% APPLY TO WART AT BEDTIME *KEEP ON PERSON* FOR 60 DAYS AVOID APPLYING TO HEALTHY TISSUE																															
RX: 7068162 WEBB, H.P., MARTY, NP START - 03/09/2005 STOP - 03/07/2005																															

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE																															
CHARTING FOR		04/01/2005										THROUGH										04/30/2005									
Physician		WEBB, H.P., MARTY										Telephone No.										Medical Record No.									
Alt. Physician												Alt. Telephone																			
Sergles		NONE KNOWN										Rehabilitative Potential																			

Diagnosis

Medicaid Number:

Medicare Number

Controlle Entries Checked:

By:

Title:

PATIENT

PATIENT CODE

ROOM NO.

BED

FAC

MEDICATION ADMINISTRATION RECORD

STDIG:

[illegible]

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 3-8-05

THROUGH 3-31-05

Physician: M. W. Phillips CRNP

Att. Physician

Telephone No. _____

Alt. Telephone

Rehabilitative
Potential

Medical Record

1674

Diagnosis

1. *Environ. Biol. Fish.* 1997, 48: 171-180.

Medicare Number

Complete Entries Checked:

By:

Title:

Notes:

DATE

PATIENT CODE

ROOM NO.

150

FAQ

Monroe James



LabCorp Montgomery Hull
543 Hull Street, Montgomery, AL 36104-0000



Phone: 334-263-5745

SPECIMEN 026-684-3271-0	TYPE S	PRIMARY LAB YX	REPORT STATUS COMPLETE	Page #: 1
ADDITIONAL INFORMATION ECC SRC:CU FASTING: Y DOB: 9/08/1967				
PATIENT NAME MONROE, JAMES		SEX M	AGE(YR./MOS.) 38 / 4	
PT. ADD.:				
DATE OF COLLECTION TIME 1/26/2006 10:43	DATE RECEIVED 1/26/2006	DATE REPORTED 1/28/2006	TIME 14:12	3019

CLINICAL INFORMATION CD- 41147609083	
PHYSICIAN ID. PEASANT J	PATIENT ID. 167435
ACCOUNT: Staton Correctional Facility Prison Health Services 2690 Marion Spillway Road Elmore AL 36205-0000	
ACCOUNT NUMBER: 01308900	

TEST	RESULT	LIMITS	LAB
Urine Culture, Routine Result 1	Final report No growth		YX
			YX

LAB: YX LabCorp Montgomery Hull
543 Hull Street, Montgomery, AL 36104-0000

DIRECTOR: Alton Sturtevant B PhD

02/02/08

Pat Name: MONROE, JAMES

Pat ID: 167435

Spec #: 026-684-3271-0

Seq #: 3019

Results are Flagged in Accordance with Age Dependent Reference Ranges



LabCorp Montgomery Hull
543 Hull Street, Montgomery, AL 36104-0000



Phone: 334-263-5745

SPECIMEN 011-684-3179-0	TYPE S	PRIMARY LAB YX	REPORT STATUS COMPLETE	Page #: 1
ADDITIONAL INFORMATION MOU SRC:PN FASTING: N DOB: 9/08/1967				
PATIENT NAME MONROE, JAMES		SEX M	AGE(YR./MOS.) 38 / 4	
PT. ADD.:				
DATE OF COLLECTION TIME 1/10/2006 14:17	DATE RECEIVED 1/11/2006	DATE REPORTED 1/13/2006	TIME 14:24	2679

CLINICAL INFORMATION	
SRC:UR CD-41147608854	
PHYSICIAN ID. PEASANT J	PATIENT ID. 167435
ACCOUNT: Staton Correctional Facility Prison Health Services 2690 Marion Spillway Road Elmore AL 36205-0000	
ACCOUNT NUMBER: 01308900	

TEST	RESULT	LIMITS	LAB
Chlamydia/GC, DNA Probe	Negative		MB
Chlamydia, DNA Probe	Negative		MB
N gonorrhoeae, DNA Probe	Negative		
Test valid for male urethral and female endocervical specimens only.	Final report		YX
Urine Culture, Routine	No growth		YX
Result 1			

LAB: MB LabCorp Birmingham 1801 First Avenue South, Birmingham, AL 35233-0000	DIRECTOR: John Elgin N MD
LAB: YX LabCorp Montgomery Hull 543 Hull Street, Montgomery, AL 36104-0000	DIRECTOR: Alton Sturtevant B PhD

03/06/06
201

Pat Name: MONROE, JAMES	Pat ID: 167435	Spec #: 011-684-3179-0	Seq #: 2679
Results are Flagged in Accordance with Age Dependent Reference			



PRISON
HEALTH
SERVICES
INCORPORATED

DEPARTMENT OF CORRECTIONS

DATE: 1/25/06

URINALYSIS

LEUKOCYTES ⊖
 NITRITE ⊕
 UROBILINOGEN normal
 PROTEIN ⊖
 pH 8

BLOOD ⊖
 SPEC. GRAVITY 1.010
 KETONE ⊖
 GLUCOSE normal
 HCG _____

(Add: Final Labs Here)

INMATE NAME (LAST, FIRST, MIDDLE)	DOC #	DOB	RACE/SEX	FAC.
<u>MONROE, JAMES</u>	<u>167435</u>	<u>9/8/67</u>	<u>B/m</u>	<u>Elmore</u>

Handwritten initials and marks: RPK, B/m, C.V.



PRISON
HEALTH
SERVICES
INCORPORATED

DEPARTMENT OF CORRECTIONS

DATE: 1/6/67

URINALYSIS

LEUKOCYTES Trace
 NITRITE (+)
 UROBILINOGEN normal
 PROTEIN Trace
 pH 5

BLOOD (-)
 SPEC. GRAVITY 1.025
 KETONE (-)
 GLUCOSE normal
 HCG _____

(Add: Final Labs Here)

Handwritten signature
1606

INMATE NAME (LAST, FIRST, MIDDLE)	DOC #	DOB	RACE/SEX	FAC.
<u>MONROE, JAMES</u>	<u>167435</u>	<u>9/8/67</u>	<u>B/m</u>	<u>Elmore</u>

Bureau Clinical Laboratories-MtgomeryPO BOX 244018, MONTGOMERY ALABAMA 3612440...
Phone: 3342603400 FAX: (334)2749800

Page: 1

Provider:KILBY CORRECTIONAL FACILITY
P O BOX 150MT MEIGS, ALABAMA, 360570000
(334) 215-6600

Reported: 3/ 9/2005 @ 3:09 PM

Accession

Requisition #: 120725

Doctor ID: UNKNOWN

Account No: KILBY CF

CHR #: 167435

Service Area:

ID: 31773

Collected: 3/ 8/2005 @

Received: 3/ 9/2005 @ 8:49 AM

Patient:**Monroe, James,**

D.O.B.: 9/ 8/1967 37 YRS 6 MOS 1

Sex: M MALE

Phone: (000) 000-0000

Status: Final Report**Test Name****Result****Units****Normal Range****Notes****Comprehensive Metabolic Panel**

> Glucose	137	AH	mg/dL	55 - 115	
Urea Nitrogen	14		mg/dL	6 - 20	
Creatinine	1.1		mg/dL	0.5 - 1.2	
Sodium	136		mEq/L	133 - 145	
Potassium	4.0		mEq/L	3.3 - 5.1	
Chloride	100		mEq/L	96 - 108	
Bicarbonate	26.0		mEq/L	22.0 - 29.0	
Calcium	9.7		mg/dL	8.4 - 10.2	
AST (SGOT)	23		U/L	0 - 38	
ALT (SGPT)	12		U/L	0 - 41	
Alkaline Phosphatase	87		U/L	40 - 129	
Bilirubin, Total	0.4		mg/dL	0.0 - 1.0	
Total Protein	7.6		g/dL	6.4 - 8.3	
Albumin	4.5		g/dL	3.2 - 4.5	

Report Summary**Abnormal Summary**

> Glucose	137	AH	mg/dL	55 - 115
-----------	-----	----	-------	----------

Lab Director

William J. Callan, Ph.D.

Date Printed: 3/ 9/2005

3:09 PM

>>

PH - Panic High

>

AH - Abnormal High

~

A - Abnormal

Completed Between: 3/ 9/2005

- 3/ 9/2005

<<

PL - Panic Low

03/14/05
mwd

Patient Name: *James M. Hume*
 Age: *36* M F
 Date: *5/16/2002*
 #167435

HR: 85 BPM
 Intervals:
 RR 702 ms
 P 118 ms
 PR 170 ms
 QRS 78 ms
 QT 342 ms
 QTc 407 ms

Axis:
 P 73°
 QRS 66°
 T 54°
 5.70
 SINUS RHYTHM
 OTHERWISE NORMAL ECG

UNCONFIRMED REPORT



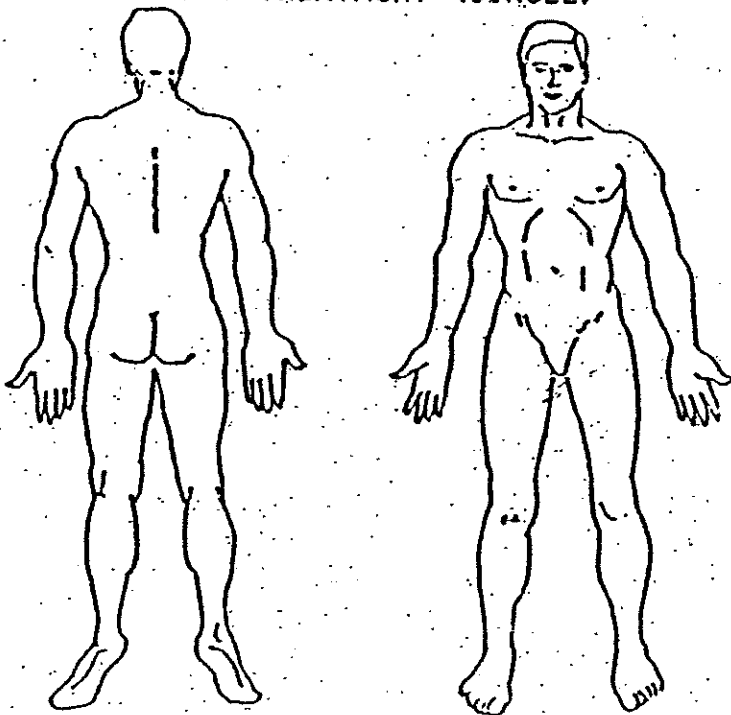
0.05-35 Hz F60 TH 10-MAR-05 07:53:44

AT-2 C X NR

TREATMENT REQUEST AND RECORD

EKG

AREA OF TREATMENT (CIRCLE)



PROGRESS NOTES:

Handwritten signature: *W. S. 1/3*

RECORD OF TREATMENT

[illegible]

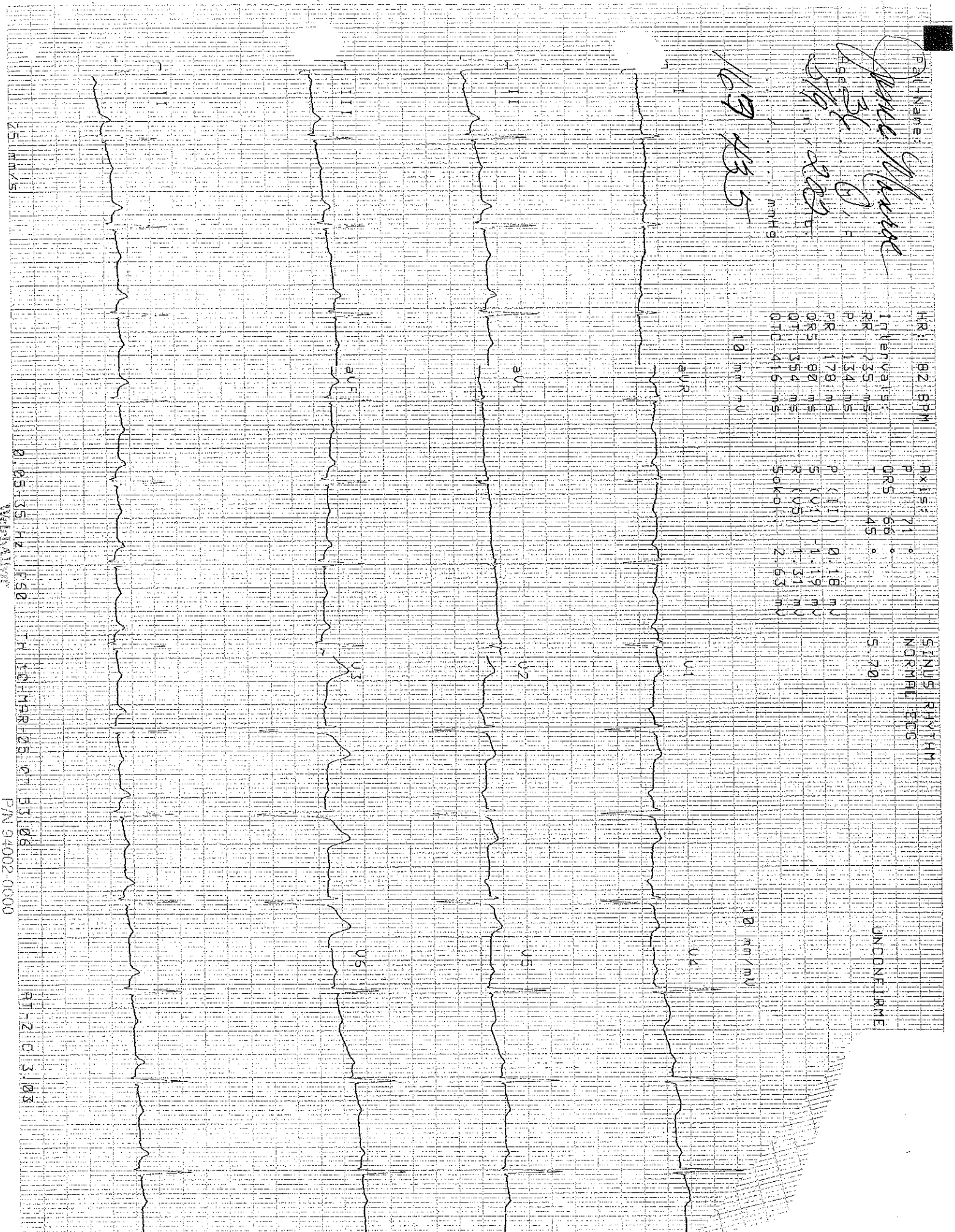
Patient's Last Name

First

Widone

Age -

P/S



Patient Name: *James M. Hurd*
 Age: *34*
 Date: *01/10/2007*
 Time: *10:30*

HR: 62 BPM
 Intervals:
 P-R 178 ms
 QRS 80 ms
 QT 354 ms
 QTc 416 ms
 Axis:
 P 71°
 QRS 66°
 T 45°
 S: 70
 UNCONFIRMED

0.05-35 Hz F50 10 MAR 05 07 53:06
 P/N 94002-0000

TB CLINICAL RECORDClinic: ☐ Outpatient ☒ Regular chest☒ First X-ray ☐ Re-X-rayDate of X-Ray 8-25-04 X-ray No. 63-26178Occupations: Present none

Past _____

MONROE, JAMES

SSN: 418-94-4089

RACE: 2

CHR: 631103799

DOB: 09/08/1967

MED:

SEX: M

DATE: 08/06/2004

ADD: RT 1 CO RD 12

FAYETTE AL 35555

PH: (205) 932-1279

36

Personal Physician(s) _____

EVALUATION: (If contact; Name of index case, why TB tested, who referred and why.)+ ppa @ Metro**CURRENT SYMPTOMS & MEDICAL HISTORY:**Loss of appetite: YES/NO NO Weight loss: YES/NO NO Fever: YES/NO NO Chest pain: YES/NO NO Night sweats: YES/NO NOHoarseness: YES/NO NO Liver disease: YES/NO NO Fatigue: YES/NO NO Dyspnea: YES/NO NOSmoker: YES/NO NO Packs per day 1 pcr Number of years _____Alcohol use: YES/NO NO Quantity: _____ Frequency _____Allergies: YES/NO NO To what: _____Productive cough: YES/NO NO

Sputum production: Color: _____ Consistency _____ Amount per day: _____ Hemoptysis: _____

Specimen collected today: YES/NO _____

Other symptoms: _____ HIV status: _____

Regular periods? YES/NO NO LMP: _____ Pregnant? YES/NO NO Contraception method: _____Present weight: 199 Usual weight: 186 Height: 5ft 9in**ANTI-TUBERCULOSIS CHEMOTHERAPY PAST & PRESENT:** (Specify drugs & dates) _____

Other medications: _____

BACTERIOLOGICAL STATUS:

Last neg smear: _____ (aerosol _____ spontaneous _____)

Last neg cul: _____ (aerosol _____ spontaneous _____ other _____)

Last pos smear: _____ (aerosol _____ spontaneous _____ other _____)

Last pos cul: _____ (aerosol _____ spontaneous _____ other _____)

Susceptibility Studies:

Date: _____

Sensitive to all drugs: YES/NO _____

Resistant to: B**MANTOUX SKIN TEST:** Date: 8-25-04 Result: (mm of induration): 8-4-04 14mm @ MetroOther skin tests: PPD RT 23 @ Metro 5 yrs agoSignature: [Signature] Date: 8/25/04**FILM INTERPRETATION:** _____

36 g/l = + PPD. 1a mate @ 5 yrs ap
 CR 8/25/04 - Clear

STATUS: (Please circle one) NORMAL/ABNORMAL -If abnormal, please circle one: Cavitory-Noncavitory-Stable-Worsening-Improving**DIAGNOSES:** (According to diagnostic standards)**RECOMMENDATIONS:**

#1

Latent TB. No Evidence of Active Disease.

Start INH per protocol.

[Signature] M.D.

Date: 8/29/04

ADPH-TB-10/Rev. 10-03 (BS)



LabCorp Birmingham
1801 First Avenue South, Birmingham, AL 35233-0000



Phone: 205-581-3500

SPECIMEN	TYPE	PRIMARY LAB	REPORT STATUS	Page #:
067-205-5253-0	S	MB	COMPLETE	2

ADDITIONAL INFORMATION

PHY-28
3/7

FASTING: N
DOB: 9/08/1967

PATIENT NAME	SEX	AGE(YR./MOS.)
MONROE,JAMES	M	37 / 6

PT. ADD.:

DATE OF SPECIMEN	TIME	DATE RECEIVED	DATE REPORTED	TIME
3/08/2005	6:42	3/08/2005	3/09/2005	7:20 3903

CLINICAL INFORMATION

CD- 41139314593

PHYSICIAN ID.
ROBBINS M

PATIENT ID.
167435

ACCOUNT: Kilby Correctional Facility
Prison Health Services
12201 Wares Ferry Road
Mt. Meigs AL 36507-0000

ACCOUNT NUMBER: 01306900

TEST	RESULT	LIMITS	LAB
CHD	<100	>100	>or=130
2+ Risk Factors	<130	>or=130	>or=130
0-1 Risk Factors	<160	>or=160	>or=190
> T. Chol/HDL Ratio	5.8H	ratio units	0.0 - 5.0
> Estimated CHD Risk	1.2H	times avg.	0.0 - 1.0
T. Chol/HDL Ratio			
Men Women			
1/2 Avg.Risk 3.4 3.3			
Avg.Risk 5.0 4.4			
2X Avg.Risk 9.6 7.1			
3X Avg.Risk 23.4 11.0			

The CHD Risk is based on the T. Chol/HDL ratio. Other factors affect CHD Risk such as hypertension, smoking, diabetes, severe obesity, and family history of pre-mature CHD.

LAB: MB LabCorp Birmingham
1801 First Avenue South, Birmingham, AL 35233-0000

DIRECTOR: John Elgin N MD

Pat Name: MONROE,JAMES

Pat ID: 167435

Spec #: 067-205-5253-0

Seq #: 3903

Results are Flagged in Accordance with Age Dependent Reference Ranges

KILBY CORRECTIONAL FACILITY
PO BOX 11
MT. MEIGS, AL 36057

PATIENT NAME

Monroe, Jane

PRISON ID

167435

DATE SUBMITTED

3-7-06

NPY 28

TEST NAME	RESULT	REFERENCE RANGE	COMMENTS
HIV ANTIBODY	NR	NEGATIVE (NEG)	
RPR	NR	NON-REACTIVE (NR)	
URINALYSIS	NEG		
APPEARANCE			
pH		pH 5- pH 6	
PROTEIN		NEGATIVE (NEG)	
GLUCOSE	3+	NEGATIVE (NEG)	
KETONES		NEGATIVE (NEG)	
BILIRUBIN		NEGATIVE (NEG)	
BLOOD		< 5 RBC/MCL	
NITRITE		NEGATIVE (NEG)	
UROBILINOGEN		< 1.0 MG/DL	
LEUK. ESTERASE		NEGATIVE (NEG)	
SPECIFIC GRAVITY		1.016-1.022	

"A"

These results are unreliable due to the age of the specimen.

"H"

These results are unreliable due to the hemolyzed condition of the specimen.

"A+H"

These results are unreliable due to the age and hemolyzed condition of the specimen.

03/10/06
mw

HCX

HEALTHCARE CORRECTIONS

RADIOLOGY SERVICES REQUEST AND REPORT

INSTITUTION: KCF

(PE)

State ID No.:

167435

DOB

9-8-67

Race:

B

Sex:

m

NOTE: PERTINENT CLINICAL INFORMATION AND TENTATIVE DIAGNOSIS MUST BE PROVIDED FOR X-RAY EXAMINATION TO BE PERFORMED

Requesting Physician/PA/NP

m Webb

Date of request

3-7-05

Time of request

2pm

Routine

Priority

Transportation or special needs

HISTORY/DIAGNOSIS:

R/O TB

X-RAY REQUEST

ABDOMEN/ABD	FINGERS	NAVICULAR VIEW	SOFT TISSUE STUDIES
ACROMIO-CLAVICULAR JOINT (W/WO WEIGHT)	FOOT	ORBIT	STERNUM
ANKLE	HAND	OS CALCEI (HEEL)	TEMPORO-MANDIBULAR JOINT
CERVICAL SPINE	HIP	PELVIS	THORACIC SPINE
CHEST PA / LATERAL	HUMERUS	RADIUS/ULNA	TIBIA/FIBULA
COCCYX	KNEE	RIBS	TOES
CONE DOWN SELLA TURCICA	LUMBAR SPINE	SACRO-ILIAC JOINT	WRIST
ELBOW	MANDIBLE	SCAPULA	ZYGOMA
FACIAL BONES	MAXILLA	SHOULDER	ZYGOMATIC ARCH
FEMUR	NASAL BONES	SKULL	

Monroe

REPORT

Chest: The heart is not enlarged. The lungs show mildly increased interstitial markings but are otherwise clear.

IMPRESSION: THE CHEST IS UNREMARKABLE EXCEPT FOR INCREASED INTERSTITIAL LUNG MARKINGS. IF AN ACUTE INFILTRATE IS SUSPECTED FOLLOW UP IS RECOMMENDED.

D & T: 03-09-05 Thomas J. Payne, III, M.D./rr Board Certified Radiologist (Signature on file)

03/10/05
mww

X-RAY TECHNOLOGIST'S NAME (PRINT)

X-RAY TECHNOLOGIST'S SIGNATURE

DATE, TIME EXAM PERFORMED

RADIOLOGIST'S NAME (PRINT)

RADIOLOGIST'S SIGNATURE



DEPARTMENT OF CORRECTIONS

MENTAL HEALTH SERVICES

DENTAL RECORD

DENTAL EXAMINATION	RESTORATIONS AND TREATMENTS
Date of Initial Examination <u>3-7-05</u>	Initial Classification _____

Oral Pathology Gingivitis _____
 Vincent's Infection _____
 Stomatitis _____
 Other Findings _____

Occlusion _____

Roentgenograms Periapical _____
 Bitewing _____
 Other _____

Health Questionnaire

YES	NO		YES	NO	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input checked="" type="checkbox"/>	V.D.
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Allergy (Novocaine, penicillin, etc.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Hepatitis
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Present Medication <u>INH</u>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Anemia or Bleeding Problems
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Heart Disease
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Asthma	<input type="checkbox"/>	<input checked="" type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input checked="" type="checkbox"/>	HIV	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Other Disease

SERVICES RENDERED

Date	Tooth #	DX	TX	Initials	Class
2-7-06	6		<p>S: R/L - "My tooth has been hurting"</p> <p>O: PA 2 #6 tap - COE never used</p> <p>#6 - Dissolving x-ray film pulp.</p> <p>A: #6 - Root canal prep - Root canal filled.</p> <p>P: Root canal filled with gutta-percha.</p> <p>Ret. Root canal filled with gutta-percha.</p> <p>L: In, m, p (1.5 cc) 1) POC 2) POC</p> <p>only - Lantid - R. M. L. Every 6 hrs.</p>		

INMATE NAME (LAST, FIRST, MIDDLE)

Monroe, James

DOC#

107435

DOB

9-8-67

R/S

Py

FAC.

KCF



PRISON
HEALTH
SERVICES
INCORPORATED

PATIENT CONSENT AND AUTHORIZATION FOR ORAL SURGERY OR EXTRACTION

Patient Name James Monroe AIS# 167435c

1. I understand that there are risks, and possible complications of oral surgery including swelling, bleeding, pain, loss of tooth parts or fillings, bone fragments, sinus involvement, infection, jaw fracture, temporary or permanent numbness or tingling of the lips, tongue, skin, gums, cheek or teeth. Some complications ~~may require further treatment and or surgery.~~
2. I consent to the use of local anesthetics or other medications and that there are possible side effects, including allergic reactions and these have been explained to me.
3. I have had the opportunity to ask questions which have been answered to my satisfaction.
4. I understand there is no guarantee of success or permanence of the treatment.
5. I authorize the disposal of any tissues, which, in the course of treatment, may be removed.

SPECIFIC TREATMENT

Tooth Number	Procedure	Date
5	Ex	3/2/06

James Monroe
Patient's Signature

[Signature]
Dentist's Signature

3-2-06
Date

3-2



**PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST**

Print Name: JAMES MONROE Date of Request: 2-22-06
 ID # 167435 Date of Birth: 9/8/67 Location: B-2-61
 Nature of problem or request: THIS IS MY SECOND REQUEST MY
TOOTH IS STILL HURTING I WOULD LIKE TO GET IT OUT
BUT IM IN PAIN,

James Monroe
Signature

DO NOT WRITE BELOW THIS LINE

Date: / /
 Time: AM PM
 Allergies:

<p>RECEIVED</p> <p>Date: <u> </u></p> <p>Time: <u> </u></p> <p>Receiving Nurse Initials <u> </u></p>
--

(S)ubjective: Tooth still hurting

(O)bjective (V/S): T: P: R: BP: WT:
Dental Screening

(A)ssessment: Extraction needed

(P)lan: Extraction appointment made
Medication Ordered

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN

CIRCLE ONE

Check One: ROUTINE () EMERGENCY (X)

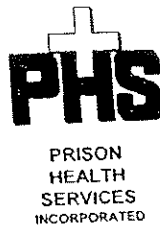
If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

[Signature]
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



PATIENT CONSENT AND AUTHORIZATION FOR DENTAL TREATMENT

Patient Name: James Monroe AIS #: 167435

1. I agree to having dental x-rays taken of my teeth and jaws in order to determine my dental problems.
2. I have had a treatment plan explained to me, including alternatives or the recommendation of no treatment.
3. I consent to the use of local anesthetics or other medications and that there may be side effects, including allergic reactions and this has been explained to me.
4. I have had the opportunity to ask questions which have been answered to my satisfaction.
5. I understand there is no guarantee of success or permanence of the treatment.

James Monroe
Patient's Signature

2-23-06
Date

[Signature]
Dentist's Signature

2-23-06
Date



PATIENT CONSENT AND AUTHORIZATION FOR DENTAL TREATMENT

Patient Name: JAMES MAJOROE ^{A15#} BCDC#: 167435

1. I agree to having dental X-Rays taken of my teeth and jaws in order to determine my dental problems.
2. I have had a treatment plan explained to me, including alternatives or the recommendation of no treatment.
3. I consent to the use of local anesthetics or other medications and that there may be side effects, including allergic reactions and this has been explained to me.
4. I have had the opportunity to ask questions which have been answered to my satisfaction.
5. I understand there is no guarantee of success or permanence of the treatment.

James Monroe
Patient's Signature

2-7-06
Date

[Signature]
Dentist's Signature

2-7-06
Date

EXHIBIT B

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

JAMES KELLY MONROE (# 167 435)

*

Plaintiff,

*

v.

*

2:06-CV-928-MEF

*

OFFICER L. THOMAS, et al.

*

Defendants.

*

AFFIDAVIT OF PAUL CORBIER, M.D.

STATE OF ALABAMA

COUNTY OF Elmore

BEFORE ME, Paul Arnold Corbier, a notary public in and for said County

and State, personally appeared **PAUL CORBIER, M.D.** and being duly sworn, deposed and says on oath that the averments contained in the foregoing are true to the best of her ability, information, knowledge and belief, as follows:

My name is Paul Corbier. I am over the age of twenty-one and am personally familiar with all of the facts set forth in this Affidavit. I have been licensed as a physician in Alabama since 2005, and have been board certified in internal medicine since 1998. I have served as the Medical Director for Staton Correctional Facility in Elmore, Alabama since July 2006. Since July 2006 my employment at Staton Correctional Facility has been with Prison Health Services, Inc. ("PHS"), the company which currently contracts with the Alabama Department of Corrections to provide medical services to inmates.

James Kelly Monroe (#167435) is an inmate who was incarcerated at Staton Correctional Facility at all times relevant to this matter. I have reviewed Mr. Monroe's Complaint in this action as well as his medical records (certified copies of which are being produced to the Court along with this Affidavit).

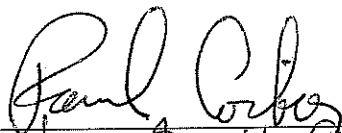
It is my understanding that Mr. Monroe has made a Complaint in this matter that Staton Correctional Facility has failed to provide him with appropriate medical treatment subsequent to being involved in an altercation with an inmate on September 4, 2006. Mr. Monroe's allegations are unfounded, as this inmate has been provided appropriate care at all times.

On September 4, 2006, Mr. Monroe was treated in the emergency room at Baptist Hospital for a stab wound to his back. He was seen the following day in follow-up in the infirmary at Staton Correctional Facility and was treated with pain medicine, antibiotics, tetanus booster and x-rays. Since that time, the staples were removed from the wound and he has received additional medication for his medical complaints. He has been treated each time he raised any health complaints.

Based on my review of Monroe's medical records, and on my personal knowledge of the treatment provided to him, it is my opinion that all of his medical conditions and complaints have been evaluated in a timely fashion at Staton Correctional Facility, and that his diagnosed conditions have been treated in a timely and appropriate fashion. At all times, he has received appropriate medical treatment for his health conditions from me and the other PHS personnel at Staton. At no time has he been denied any needed medical treatment. In other words, it is my opinion that the appropriate standard of care has been adhered to at all times in providing medical care, evaluation, and treatment to this inmate.

At no time have I or any of the medical or nursing staff at Staton Correctional Facility denied Monroe any needed medical treatment, nor have we ever acted with deliberate indifference to any serious medical need of Monroe. At all times, Monroe's known medical complaints and conditions have been addressed as promptly as possible under the circumstances."

Further affiant sayith not.



Paul Arnold Corbier

STATE OF ALABAMA)
)
COUNTY OF _____)

Sworn to and subscribed before me on this the 12 day of December 2006.



Notary Public

My Commission Expires:

12/06/2008

EXHIBIT C

IN THE DISTRICT COURT OF THE UNITED STATES
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

JAMES KELLY MONROE, (AIS #167435), *

*

Plaintiff,

*

V.

2:06-CV-928-MEF

*

OFFICER L. THOMAS, et al.

*

Defendants.

*

AFFIDAVIT OF DARRYL ELLIS, DIRECTOR OF NURSING

BEFORE ME, Annie Latimore, a notary public in and for said County and State, personally appeared **DARRYL ELLIS, DIRECTOR OF NURSING**, and being duly sworn, deposed and says on oath that the averments contained in the foregoing are true to the best of her ability, information, knowledge and belief, as follows:

“My name is Darryl Ellis. I am over the age of twenty-one and am personally familiar with all of the facts set forth in this Affidavit. I have been a licensed, registered nurse in Alabama since 1995. I hold an Associates Degree in nursing from Troy State University. Since 1995, I have practiced as a registered nurse in a variety of positions and settings. In particular, I have worked at Staton Correctional Facility in Elmore, Alabama as a LPN since 1985 and as a registered nurse since 1995. Since October 2005, I have been employed as the Director of Nursing for Staton Correctional Facility by Prison Health Services, Inc., the company which currently contracts with the Alabama Department of Corrections to provide medical services to inmates.

Prison Health Services, Inc. (PHS) has established a simple three-step procedure for identifying and addressing inmate grievances at Staton Correctional Facility. If an inmate has a grievance regarding a healthcare issue he must submit to the healthcare unit a "Medical Complaint Form." These are standard forms that may be requested from an inmate's supervising officer in his dormitory. The inmate medical complaint form allows an inmate to communicate any healthcare related concern by placing the medical complaint form in the sick call box or mailbox to be forwarded to the healthcare unit. I subsequently review the request and respond accordingly via in-house mail. Also, when deemed necessary, the inmate will receive a face-to-face interview with me or the doctor or both. At this time, the needs of the inmate are addressed and treatment is discussed.

If an inmate is unsatisfied with my response, he may request an "Inmate Formal Grievance" form from the healthcare unit. This form allows an inmate to again voice his concerns relating to the healthcare issue addressed with the medical complaint form. I again respond to the inmate via in-house mail.

If the inmate is still unsatisfied with my response, he or she may request from the healthcare unit an "Inmate Grievance Appeal" form. This form is again submitted to me and represents the final step of the appeal process. After an inmate submits an inmate grievance appeal, I will meet with the inmate face-to-face in a final attempt to address his concerns verbally.

It is my understanding that James Kelly Monroe has filed suit in this matter alleging that PHS has failed to provide him with appropriate medical treatment subsequent to being involved in an altercation with an inmate on September 4, 2006. However, Mr. Monroe has failed to exhaust Staton's informal grievance procedure

relating to the receipt of medical care for this alleged condition. Specifically, Mr. Monroe has not submitted all appropriate and required forms. As such, the healthcare unit at Staton Correctional Facility has not been afforded the opportunity to resolve Mr. Monroe's medical complaints prior to filing suit.

Further affiant sayeth not.

Darryl Ellis, DON
DARRYL ELLIS
DIRECTOR OF NURSING

STATE OF ALABAMA)
)
COUNTY OF Elmore)

Sworn to and subscribed before me on this the 8th day of
January, 2007.

Annie Latimer

Notary Public

My Commission Expires:

12/06/2008

EXHIBIT D

POLICY/PROCEDURE Prison Health Services, Inc	Date of Origin: 11/03/03 Date of Previous: Revised Date: 1/1/05 Revised Date: 5/18/05
	Page 1 of 1
FACILITY NAME: Alabama Department of Corrections	COUNTY: STATE: Alabama

TITLE: Grievance Mechanism for Health Complaints

NUMBER: GP011

REFERENCE: NCCHC : P-A-11; ACA Standard 1-HC-3A-01

POLICY:

It is the policy of PHS to encourage the resolution of inmate concerns regarding the health care system prior to the documentation of a written grievance. A grievance mechanism addresses inmate's complaints about health services.

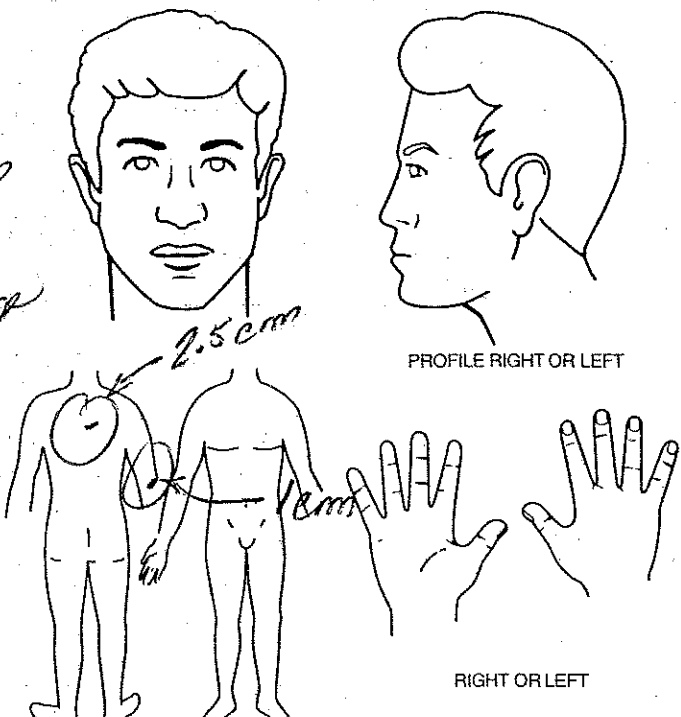
PROCEDURE:

1. The Health Administrator will work with the facility administrator to ensure that there is a well-defined procedure for handling inmate grievances and appeals.
2. When a grievance about health care services is received (inmate grievance), the medical record is reviewed, and if necessary, the inmate is interviewed. A review of the grievance occurs within 3 days after receiving the grievance and answered.
3. Immediate resolution is expected if the grievance involves the inmate's access to health care. The Warden or Warden's designee will be copied.
4. Every effort will be made to resolve the inmate's grievance to his/her satisfaction.
5. If the grievance cannot be resolved to the inmate's satisfaction, the inmate may request an appeal in which case the written grievance will be reviewed through the facility review process and answered within 5 days.
6. Separate logs will be maintained for grievances and grievance appeals.
7. Summary review of inmate health care (grievances and grievance appeal logs) are included in the Quality Improvement meetings and identified problems are viewed as opportunities to improve care.

EXHIBIT E

EMERGENCY

028971

ADMISSION DATE 9/4/06		TIME 740 <small>AM PM</small>	ORIGINATING FACILITY Station		<input type="checkbox"/> SICK CALL <input type="checkbox"/> EMERGENCY <input checked="" type="checkbox"/> OUTPATIENT																									
ALLERGIES NKA			CONDITION ON ADMISSION <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR <input type="checkbox"/> SHOCK <input type="checkbox"/> HEMORRHAGE <input type="checkbox"/> COMA																											
VITAL SIGNS: TEMP 98.3		ORAL RECTAL	RESP. 20	PULSE 96	B/P 160/96	RECHECK IF SYSTOLIC <100> 50																								
NATURE OF INJURY OR ILLNESS B- I was just sitting watching TV when somebody came and started stabbing people. C- A0X3. Skin w/o keep clear. Noted 2.5cm stab wound on @ side of spine below shoulder blades. @ dressing at present. 1cm laceration @ @ elbow & blood flow @ slow rate. @ pain when asked to take a deep breath to check lung sounds. Pain continuous. A- Maint. punctured wound to p- Reported to Rls Corbin To be sent to Bapt So ER via van.			<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>ABRASION ///</td> <td>CONTUSION #</td> <td>BURN <small>xx</small> <small>xx</small></td> <td>FRACTURE <small>Z</small> <small>Z</small></td> <td>LACERATION / SUTURES</td> </tr> </table> <div style="text-align: center;">  <p>2.5cm</p> <p>1cm</p> <p>PROFILE RIGHT OR LEFT</p> <p>RIGHT OR LEFT</p> </div>				ABRASION ///	CONTUSION #	BURN <small>xx</small> <small>xx</small>	FRACTURE <small>Z</small> <small>Z</small>	LACERATION / SUTURES																			
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ORDERS / MEDICATIONS / IV FLUIDS	TIME	BY																												
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INSTRUCTIONS TO PATIENT																														
DISCHARGE DATE 9/4/06		TIME <small>AM PM</small>	RELEASE / TRANSFERRED TO		<input checked="" type="checkbox"/> DOC <input type="checkbox"/> AMBULANCE <input type="checkbox"/>																									
NURSE'S SIGNATURE [Signature]		DATE	PHYSICIAN'S SIGNATURE		CONDITION ON DISCHARGE <input type="checkbox"/> SATISFACTORY <input type="checkbox"/> POOR <input type="checkbox"/> FAIR <input type="checkbox"/> CRITICAL CONSULTATION																									
INMATE NAME (LAST, FIRST, MIDDLE) MONROE, James			DOC# 167435	DOB 9/8/67	R/S Btm	FAC. Sec																								